Parkway FAMILY EYE CLINIC

Financial Policy Agreement (FPA)

Thank you for choosing Parkway Family Eye Clinic, Inc. (PFEC) to treat your eye care needs. We are committed to excellent patient care. Below we have provided an explanation of our Financial Policy Agreement (FPA). Patients must complete the FPA prior to receiving services.

Please initial the following:

_____ 1. Each patient is responsible for his or her own bill. Your insurance policy is a contract between you and your insurance company; therefore, payment of all co-payments, co-insurances, and/or deductibles must be paid in full, at each visit, prior to rendering services. Fees for services associated with any office visit are non-refundable. We accept cash, checks and all major credit cards. There is a **$30- $50 fee** on all returned checks.

_____ 2. As a courtesy, PFEC will file claims to your insurance carrier(s). To accomplish this, you must provide the most up-to-date insurance information and any changes to our office. If the insurance company(s) that you designate is incorrect, you will be responsible for payment of the visit. Your bill is your responsibility, whether or not your insurance company pays.

_____ 3. "Self-pay" patients are required to pay 100% of exam services rendered, prior to each visit. Infection rechecks within two weeks of the initial visit, are covered at no additional cost, unless a new problem occurs. Eyeglass or contact lens purchases require at least a 50% deposit prior to processing the order; **all deposits are non-refundable.**

_____ 4. If your insurance carrier does not remit payment within **60 days** from the time of billing, the balance will be due in full from you. If any insurance or third party payment is paid directly to you for services billed by our office, you are responsible for remitting prompt payment to our office. In the event that you are billed for services, invoices that go unpaid for **90 days** will be turned over to a third party and/or collection agency. I understand and agree, if I fail to make timely payments for balances owed, I will be responsible for all costs of collecting unpaid balances, including any court costs, collection agency fees, and attorney fees.

_____ 5. As a specialty group, some insurance companies require an authorization or referral be obtained prior to your visit. It is your responsibility to know if your insurance requires this and to obtain the referral/authorization before your visit. If this is not done by the day of your appointment, you will be asked to reschedule or to pay for the FULL amount of the visit. If a claim is rejected because a valid authorization or referral was not in place, the full cost of the visit will be the patient's responsibility.

_____ 6. From time to time, you may ask us to complete various forms (such as disability forms). There is a **$15 service fee** to complete these forms. Payment is due prior to giving you back those completed forms. This charge is not covered by your insurance company and offsets the costs we incur to complete these forms. Please allow 5 to 10 business days for completion.

_____ 7. We may charge up to **$25** for the reproduction of your medical records based on guidelines from the State of Georgia and the Federal Government.

_____ 8. I understand that failure to maintain a current account with Parkway Family Eye Clinic, Inc. may result in further non-emergent medical treatments not being provided and/or dismissal from the care of Parkway Family Eye Clinic, Inc.

_____ 9. AUTHORIZATION TO PAY BENEFITS: I authorize and direct said agency or insurance company to pay benefits, or insurance payments made on my behalf, directly to Parkway Family Eye Clinic, Inc. for professional services rendered. I understand this in no way relieves me of my personal responsibility for paying my responsible portion when a statement is rendered. It is understood that the signing of this form does not prohibit customary monthly billings.

By signing below, I acknowledge receipt of this FPA.

X _____ X _____ Date: _____/_____/_____

Print patient name Patient/ Guardian Signature