COLUMBIA BASIN EYE CLINIC PS

Billing Policy Information

We participate with the following medical and vision insurance plans. If your insurance company is not listed below, please ask our staff regarding our participation status.

- Medicare
- Premera Blue Cross/all Blue Cross Blue Shield/Regence Uniform Medical
- CHPW – HO
- Asuris
- DSHS
- First Choice
- Health Alliance
- Soundpath
- Molina

(Co-pays and deductibles are payable at the time of service for these plans)

We are NOT preferred providers for Vision Service Plan, Cole Vision, Spectera, Northwest Benefits, Coordinated Care, EyeMed or UHC

Medical Insurance:

• If you have Medicare we will bill one supplemental plan as a courtesy. **If your insurance plan is not listed above, your office visit is payable at the time of service**. We will, **as a courtesy**, bill your insurance plan so they may reimburse you directly. Most insurance plans pay claims within 45 days. We will work with you to make payment for major services, such as lasers and surgeries, as convenient as possible. **Please notify our receptionist upon registration if you need to make financial arrangements.**

• All tests and pictures performed in our office are billable to your medical insurance only.

Vision Insurance:

• Please be aware in advance, routine eye exams and refractions (the portion of the exam which determines your best corrected visual acuity with lenses) are **not** covered by Medicare and most insurance carriers. These vision services are covered under vision insurance plans, not medical insurance plans. **The charge for refraction is payable at the time of service. If you do not want a refraction done, please notify the doctor's assistant immediately prior to your examination. Contact lenses are not covered by your insurance and there is a $30 fee payable at time of service.**

Statements:

If you receive a statement from us, our terms are 30 days. **Please remember the responsibility of payment is your direct obligation**. Payment may be made by check, cash, money order, Visa and MasterCard. If a check is returned to us due to insufficient funds, our returned check fee is $45.00 and you will be required to pay for future services via cash or money order.

Assignment of Benefits for Participating Plans

I authorize payment directly to Columbia Basin Eye Clinic PS those benefits otherwise payable to the patient or the patient's guardian for those services provided by my doctor. If my current policy prohibits direct payment to the doctor, then I hereby also instruct and direct my insurer to make out the check to me and mail it to my doctor as follows: c/o Columbia Basin Eye Clinic PS. I hereby authorize my insurance and government benefits to be paid directly to Columbia Basin Eye Clinic, PS. **I am financially responsible for any balance due because of co-pay, deductible, referral or authorization not obtained prior to visit, or incorrect insurance information. A $20.00 billing fee will be added each month that we send a statement to you.**

Release of Information

I agree that, to the extent necessary to determine liability for payment and to obtain reimbursement to Columbia Basin Eye Clinic PS for services rendered, all or portions of the patient's record may be disclosed to any person or corporation (or any agent of such person or corporation) which is or may be liable for any portion of the charges made by my doctor, including without limitation, insurance carriers, health care services plans, workers compensation carriers and/or employers.

If it is necessary to employ an attorney or agent to enforce this document, or collect any judgment based on this document, I promise to pay all court costs and fees, whether taxable or not, in all courts, including bankruptcy and appellate courts.

The undersigned certifies they have read the foregoing and accept its terms.

____ __________________

Signature of Patient or Legal Representative **Date**