# COCHISE EYE & LASER

## Our Financial Policy

We are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

- All patients must verify their demographic information before seeing a doctor.
- Insurance card(s) **MUST** be presented at **EVERY** visit.
- Co-pay(s) and Refraction charges (if applicable) **WILL** be collected prior to each visit.
- For Eye Glasses and Contact Lenses, you must pay 50% down at time of ordering and the balance at the time you receive the order.
- If you are self-paying (have no insurance), full payment is due at time of service and will be collected at the end of your visit with the physician.
- We accept cash, checks, Master Card, VISA, and Discover card.

**YOU ARE RESPONSIBLE FOR THE TIMELY PAYMENT OF YOUR ACCOUNT REGARDLESS OF WHETHER YOU CARRY INSURANCE OR NOT.**

**It is REQUIRED that we see your insurance card(s) prior to each visit if you have insurance.**

We are contracted with most major MEDICAL insurance companies; however, we are NOT contracted with many VISION care companies. It is your responsibility to ascertain if we are contracted with your insurance company at the time of requesting services (e.g., making an appointment). In addition, it must be understood that your insurance is a contract between you and that insurance company. While we will file insurance claims as a courtesy to our patients for those insurance companies with which we have a provider contract, we will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, “usual and customary” charges, etc., other than to supply factual information necessary.

If you have insurance, we do our best to ensure you receive maximum benefits but it is your responsibility to be aware of your benefits and your financial obligations relative to your insurance. In addition, you are responsible for all co-pays and deductibles. If the doctor believes that a specific test is necessary and there is a possibility that the test may not be covered by your insurance, you will be asked to sign a form known as an “Advance Beneficiary Notification” that states your responsibility for payment in the event your insurance does not cover the test and you agree to have the test performed.

For all other insurance companies with whom we are not contracted, you must pay for your visit at the time of services and we will furnish you with a receipt with information your insurance company requires to reimburse you.

If your insurance company has not paid the FULL BALANCE within 45 days, you have 15 days to pay the balance. If your insurance company pays more than the balance due, we will send a refund check to you immediately. **Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.**

Responsible Party’s Signature _____ Date _____