BALOURIS EYE CENTER, PC

FINANCIAL POLICY

We are committed to providing you with the highest level of service and quality care. If you have medical insurance, we will strive to help you receive your maximum allowable benefits. Our office participates with most major medical insurance plans. In order to achieve these goals, we need your assistance and understanding of our financial policy.

CO-PAYS (A co-pay is a fixed amount you pay for a health care service, usually an office visit, that is determined by your health care plan, and is indicated on your insurance card.) **This is collected at the time of service. If you do not pay your co-payment at the time of the visit, you will be charged an additional $5.00 billing fee. We accept cash, checks, and all major credit cards for services.**

DEDUCTIBLE (Your deductible is the amount of expenses that must be paid per year, out of pocket, before an insurer will pay any expenses. **(Your deductible will be billed to you once the insurance claim has been processed, and is payable to the office within 30 days.)**

SURGERY (If a surgery is scheduled and a deductible has not been paid.) **A deposit for surgery fees will be required if there is an unpaid deductible remaining on your insurance plan.**

CO-INSURANCE (Co-insurance, if applicable, is usually figured as a percentage of the allowed charge.) **Co-insurance will be billed to you once the insurance claim has been processed, and is payable to the office within 30 days.**

REFRACTION (Exam process to determine your corrective lenses.) **A refraction is considered a non-covered service by most all insurance companies, including Medicare. If you receive a refraction, you will be charged a fee of $25.00 which is due at the time of the service. If you do not want a refraction please let the technician know when they take you back for your exam.**

APPOINTMENT CANCELLATIONS (We understand that there are occasions when an appointment must be cancelled. In this event, it must be cancelled within 24 hours of the scheduled visit. This allows the staff enough time to schedule another patient who is in need of medical care.) **A fee of $25.00 will be charged to the patient if a 24 hour cancellation notice is not given.**

NO SHOW APPOINTMENTS (Patient does not cancel and does not come to the scheduled appointment.) **A fee of $25.00 will be charged to the patient and the patient could be terminated from the practice.**

NSF CHECKS (Check payments that do not clear the bank.) **There will be a return check fee of $30.00.**

COMPLETION OF FORMS (There is a charge for completing various forms, including your DMV form.) **Pre-payment is required for completing forms, or for extra written communication by the doctor. The charge is determined by the complexity of the form, letter, or communication.**

I have read and understand the above financial policy.

Patient Signature: _____ **Date:** _____/_____/_____/

Print Name of Patient: _____ **Date:** _____/_____/_____/