Wolfeboro Eye Associates - Financial Policy

Patient Name:

- Co-payments and self pay balances are due at the time of service.
- Please check with your health insurance carrier before services are rendered to verify that your insurance covers the services you are requesting and that our office participates with your insurance carrier.
- If your insurance carrier requires a written referral for you to be seen at our practice we ask that you come prepared with the appropriate referral. Please understand that we must stay within the guidelines of the referral when providing your care.
- Effective Jan 1, 2013, there will be a 10% finance charge added to accounts with open balances over 90 days. Any accounts with open balances over 120 days will be forwarded to collections.
- There will be a $20 fee for checks returned for Non-Sufficient Funds (NSF).
- We accept cash, checks, and Visa, MasterCard, and Discover credit or debit cards. We do not accept American Express. We do not offer credit terms in-house, however we participate with CareCredit, a nationally recognized short- to medium-term (6-60 months) medical lender and we will be please to assist you to set up an account with them.
- We reserve the right to charge patients $25.00 if you do not show for your scheduled appointment or if you cancel with less than 24 hours advance notice. _____ **(Initials)**

I, the undersigned, certify that I (or my dependent) have health insurance coverage and assign directly to Wolfeboro Eye Associates, Inc. all insurance payments for services rendered. I understand that I am financially responsible for all charges not covered by or denied by my insurance company. I hereby authorize the release of information necessary to process insurance claims. I understand that non-payment of my insurance premiums will result in no coverage by my insurance company. **If you do not have insurance, or have not paid your premiums, payment in full is expected at the time of service.** Please consult our front office staff for payment options.

I have read and understand the Wolfeboro Eye Associates Financial Policy.

Signature of Patient or Legal Guardian	**Today's Date:**

Wolfeboro Eye Associates, Inc. participates with most major health insurance companies, however, ***it is <u>your</u> responsibility to know your insurance coverage. We submit to your insurance but you are responsible for keeping your information up to date and you are financially responsible for what insurance does not cover.***

Please present your current insurance card(s) to the receptionist.