IDAHO EYE and LASER CENTER

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THE IDAHO EYE CENTER AND YOUR INSURANCE

The physicians in our office are specialists who have received extensive training in health services of the eye. The fees for the services we provide are established based upon the skills, training, and time required by the physician to complete your examination and/or procedure.

PLEASE CONTACT YOUR INSURANCE COMPANY TO VERIFY THAT WE ARE A PARTICIPATING PROVIDER WITH YOUR PLAN

REFERRALS

Medicaid Healthy Connections require a referral from the Primary Care Physician. Referral forms should reach our office prior to your appointment, or you may bring it with you the day of your examination. If we do not have a referral for you on the day of your appointment you have the option of rescheduling your appointment, or you may elect to proceed with the visit, but you will be required to pay for services in full at that time.

SUBMISSION OF INSURANCE CLAIMS

To assist our billing staff in submitting your insurance claims we will check eligibility, verify benefits and check for pre-authorization requirements with your primary insurance prior to surgery. Please remember that verification of benefits is not a guarantee of payment. Your insurance company reserves the right to process or deny benefits upon receipt and review of all claims. The Idaho Eye Center will submit your Primary and Secondary insurance claims. Any Tertiary insurance coverage will be your responsibility to submit for reimbursement.

INSURANCE BENEFITS

Insurance companies base the amount they pay on their allowable and the policy's deductible.

- Allowable: What the insurance company has established as the dollar amount upon which they base their payments for the service / procedure.
- Deductible: Your payment responsibility each policy year and / or with different types of services.
- Co-payments: designated dollar amount, separate from co-insurance, that the insured is financially responsible for and must pay to a Provider at the time certain Covered Services are rendered.

The allowances made by your particular insurance company are separate and apart from the fees that we charge. When a non-participating company does not allow or pay all of a given medical expense, the wording they often use is "the fee charge exceeds the usual and customary allowance for this procedure." This means your policy does not fully pay for the services due to policy limitations-not that the fee is excessive. You are responsible for the entire balance after your insurance pays their allowable benefits.

You are also responsible for all co-pays and deductibles as specified by your insurance company at the time of service. Balances are due 120 days after your insurance has paid its portion of benefits.

Our insurance policies:

- Your insurance policy is a contract between you and your insurance company; we are not a party to that contract.

- If your insurance company has not paid your claim within 45 days, the balance will be due and payable by you. If you have a secondary or supplemental policy the balance will be due after 60 days. We will also work with you to establish payment arrangements if necessary. These arrangements need to be made prior to services received.
- Insurance payments that you receive directly must be forwarded to the Idaho Eye Center.

The Idaho Eye Center will begin charging a "Late Payment" fee of 1.5% per month (18% annually) on all past due accounts starting on January 1, 2016. This charge will apply to patient balances that are still owed 120 days past the date the balance is turned to "patient responsibility". To avoid the interest charge, your account must be current at all times. Initial and date that you have read and understand this paragraph. _____

YOUR INVOLVEMENT

The Idaho Eye Center will work closely with you to obtain the maximum benefits from your insurance company. While we make every effort to help patients receive their insurance benefits, insurance companies are often more responsive to their customers, the patients. To improve the payment process, our office may ask you to contact your insurance company personally.

INSURANCE ASSIGNMENT AND RELEASE OF RECORDS

I hereby authorize the Idaho Eye and Laser Center, to release by electronic means or otherwise any medical and/or billing information concerning my care, including copies of my medical records to any person or entity responsible for payment for the medical services rendered to me at the facility, including third party payors, self-insurers, worker's compensation carriers and government agencies.

I also release information to any health professionals involved in my care for the purpose of facilitating the continuity of my medical care. I acknowledge that this authorization has no expiration date and is valid to authorize the release of medical records and billing information at any time a valid request is received.

I hereby authorize my Medicare and/or medical insurance benefits to be paid directly to Idaho Eye and Laser Center. I understand that I am financially responsible for non-covered services as well as any deductibles, coinsurance or amounts in excess of insurance benefits. If coverage is denied, I give my express consent to appeal to the insurance on my behalf.

FINANCIAL RESPONSIBILITY

In consideration of services rendered or to be rendered to the patient designated herein at my request for this occasion of service, I guarantee and agree to pay charges for those services rendered including any amount not paid by my insurance plan, Medicare, health service plan or health maintenance organization. By signing the financial responsibility statement, the patient and guarantor(s) acknowledge and agree they are responsible for payment of billed charges rendered in any case in which payment may be denied by the health maintenance organization (or preferred provider organization) because of a failure to comply with such coverage requirements or for any other reason. A copy of this form shall have the same force and effect as the original.

I acknowledge that I have read and understand its contents fully. The undersigned is the patient, the patient's legal representative or is authorized by the patient to execute this form and accepts its terms.

_____ _____

Signature of patient or person authorized to sign for patient Date

_____ POA: ☐ Yes ☐ No _____

Relationship to patient Witness