Charleston Cornea Refractive Surgery, P.A.
Financial Policy:

Thank you for choosing us for your eye care needs. The following is our financial policy for you to read and sign prior to any treatment. This information is also available on our website at www.charlestoncornea.com:

PATIENT REGISTRATION

- You will be asked to complete a registration form each year, update and confirm the accuracy of this information at every visit.
- For your protection, we require personal identification. Bring your driver's license or picture ID on every visit to the front office check in system.
- Our registration form is available on our website.

CANCELLATION AND NO SHOW POLICY

- We require a 24 hour notice if you wish to cancel or reschedule your appointment.
- A $35.00 fee will be charged if you miss an appointment without notifying us, or rescheduling with less than 24 hour notice.
- A non-refundable $50.00 security deposit will be required to make an appointment for patients who frequently "no show".

INSURANCE CARDS AND INSURANCE FILING

- As a courtesy to all our patients, we will file insurance claims to your primary and secondary insurance carrier.
- You must bring your current insurance card to every visit to file insurance claims on your behalf. It is your responsibility to inform us in a timely manner of any changes to your billing information.
- If an insurance company denies payment for incomplete or incorrect information provided by you or for non-covered services, you will be expected to pay for services in full.
- If we do not participate in your insurance plan, be aware your benefits may be reduced.
- Medicare and most insurance companies DO NOT cover standard care of eye refraction, (eyeglass prescriptions).
- Charleston Cornea's refraction fee is $35.00.
- We do not file school or automobile insurance.

INSURANCE AUTHORIZATION

- If your insurance requires an authorization for office visits or procedures, it is your responsibility to make sure we have authorization prior to the visit or service.
- If you want to be seen without an authorization, you will be considered a self-paying patient, and you will be required to pay in full for all services at the time you are seen.

PAYMENT

- We accept Cash, Check, Money Order, Visa, MasterCard, Discover, and American Express.
- Patients are expected to pay for all estimated co-pays, outstanding deductibles, and coinsurance **AT THE TIME OF SERVICE** as required by your insurance company.
- Patients will also receive a monthly statement for any unpaid services by patient or insurance.
- Returned check fee is $25.00
- Medical record fee of $25.00 in advance for completion of disability forms.

SELF PAY/ UNINSURED

- It is impossible to determine what the cost of the care will be prior to the date of service
- We require a minimum payment of $100.00 up front before seeing one of our doctors for new self-pay patients.
- Additional payment may be required after services rendered.
- Patients who do not have insurance will receive a 20% discount on charges if paid in full on date of service.
- Patient will be billed for any balance not paid at checkout. Payment is due upon receipt of statement.

MINOR PATIENTS

- Patients under the age of 18 must be accompanied by a parent or guardian.
- The parent who consents for treatment will be the responsible party on the account and is responsible for all charges regardless of divorce or separation decree.
- We request patients age 18 or older covered under their parents insurance to sign an authorization allowing Charleston Cornea & Refractive Surgery, P.A. to contact parents regarding insurance and billing issues.

EXTENDED PAYMENT PLANS AND FINANCIAL ASSISTANCE

- Please call our billing office to discuss any extended payment plan options, which may be available to you under hardship circumstances.

TERMINATION / DISCHARGE FROM PRACTICE

- The following scenarios may jeopardize the patient/ physician relationship in which Charleston Cornea & Refractive Surgery, P.A. will terminate and discharge the patient from the practice. The patient will be sent a letter of discharge for:
    - Noncompliance/ Abusive Patients
    - Excessive no shows
    - Financial –failure to meet financial obligations

Please direct any question concerning the above policy to our business office at 843-856-5275.

By signing below, I acknowledge that I have read and understand the financial policy set forth by Charleston Cornea & Refractive Surgery, P.A.

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Name of Patient / Responsible Party Date