Ophthalmology Associates & LASIK Center
of Mankato P.A.

1630 Adams Street, MN 56001
507-345-6151/888.605.5189
www.mankatoeyedoctors.com

PATIENT FINANCIAL POLICIES

Billing/Insurance information:
You must provide your insurance information and a copy of your ID card(s) at each visit. **Payment of your required co-pay and any non-covered services are required at time of service.**

We participate or contract with most major insurance carriers, including Medicare and Medicaid, but it is your responsibility to confirm benefits and coverage prior to services provided. We will submit claims to your insurance carrier, but you remain responsible for any charges incurred regardless of your insurance coverage. All unpaid balances will be billed to you as self-pay and are due and payable **within 30 days of the statement date**. Past due balances may be subject to outsourcing to a third-party agency for collection, interest charges (after 30 days of the statement print date), and collection fees.

Your insurance carrier can tell you whether we are contracted with them. For any insurance plans that we do not participate or contract with, you are responsible for any unpaid balance. If unable to pay in full, you must make payment arrangements with our billing staff.

It is your responsibility to:
- Know your insurance benefits and coverage.
- Know whether a referral is required.
- Know whether pre-certification for a procedure or surgery is required.
- Notify us of changes to your insurance plan or coverage.

Managed Care Medicaid and Managed Care Insurance recipients MUST bring a copy of the referral card from your primary-care physician or your appointment may be rescheduled. If you choose to be seen without a required referral, you accept responsibility for payment prior to services provided. (This does not apply to Medicare patients).

Medicare:
I request that payment of authorized Medicare benefits be made on my behalf to OAM for services furnished me by OAM. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. OAM accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

OVER

Payment methods:
We accept cash, check, Visa, MasterCard, Discover, American Express, Diners Club, and JCB International credit cards. You may pay in person, over the phone, or securely and conveniently online on our website via credit card at www.mankatoeyedoctors.com under "PAY MY BILL."
Please note: Any payment made by check that does not clear your bank account will result in a $25 return check fee, which will be added to your account and must be paid before the next visit.

Financing with Wells Fargo, Care Credit and Alphaeon:
These programs can offer interest-free loans on balances of $300 or more that are paid within 18 months and interest-bearing loans on balances of $1,000 or more that are paid within 24-60 months. You may apply on our website or request details and an application from our billing staff; or they also can approve you right here in house.

Payments and payment plans:
As a convenience, you may use our secure form to pay your bill online by visiting our website at www.mankatoeyedoctors.com or request an approved payment plan by contacting our billing department. This option offers automatic monthly credit card charges until your account is settled in full. All payment plan requests must be approved by our billing supervisor/administrator.

Pre-authorization:
Our billing staff will assist in obtaining any required pre-authorizations and benefits detailing your financial obligations prior to your procedure or surgery.

Self-pay patients:
Payment is expected at time of service. Payments may be made by cash, check, money order, or credit card. **Minimum payment and balance due requirements:** If you do not have insurance and are unable to pay in full, we require a minimum payment of $100 prior to providing office services as a new patient. For subsequent visits, a minimum of $50 is required. Any balance due requires approved payment arrangements by our billing staff. Fees for additional services such as diagnostic tests, drugs, and surgery will also require approved payment arrangements.

Minor/dependent Patients:
For all services rendered to a minor/dependent patient, the parent/guardian accompanying the patient is responsible for payment. In cases of separation or divorce, when presenting insurance cards for a dependent enrolled under a subscriber other than you, please be prepared to supply their name, address, phone number, date of birth and social security number. We request that you inform the subscriber that their insurance has been used.

Acknowledgment and signatures:
By signing below, I acknowledge that I have read and understand the above Financial Policy. I understand and agree that I am financially responsible for all charges for services rendered. I hereby assign all insurance benefits to which I am entitled to Ophthalmology Associates & LASIK Center. I authorize the use of this signature on all insurance claims. I authorize Ophthalmology Associates & LASIK Center to release all information necessary to secure payment of benefits.

_____	_____	_____
Printed name of patient	SSN or driver's license number	Patient's date of birth
_____	_____	_____
Signature of patient/parent/guarantor	Printed name of parent/guarantor	Date