**THE MAY EYE CARE CENTER & ASSOCIATES FINANCIAL POLICY**

Thank you for choosing The May Eye Care as your eye care provider. The following information is designed to help you understand our financial policies. As we enter into a doctor-patient relationship, we agree to provide you with quality medical care and you agree to be prepared to pay your obligation at the time of service and understand your obligation as set by your insurance company.

**ADMINISTRATIVE REQUIREMENTS:** All new patients are required to complete in its entirety:

the patient information sheet, health survey, consent allowing other individuals access to your PHI and accounting information along with acknowledgement form for HIPAA. As an established patient, you will be expected to update all demographic and insurance information at each visit. You are required to provide at each visit: all insurance cards, photo ID, and a current list of medications along with the names and addresses of any other provider that you wish to receive a letter regarding your exam findings.

**APPOINTMENTS:** Please remember that when you book an appointment, you have reserved time.

Please be on time for your appointment and give yourself time to register upon arrival. If you need to

cancel or reschedule, please provide at least 24 hours notice. If your appointment is made the same

day and you are unable to keep it, please notify us as soon as possible. Arriving early for an

appointment does not necessarily mean you will be seen early. If you arrive late, you will need to wait

until you can be fit back into the schedule. If you miss your appointments, you will be subject to a

service fee for all future missed appointments.

**APPOINTMENTS FOR MINORS:** All patients under the age of 18 must be accompanied by a parent or legal guardian throughout the entire exam.

**PAYMENT REQUIREMENTS:**  Copayments, non-covered charges, and deductibles are due at the time of service. Account balances will also be collected at the visit. Payments are accepted in the form of check, cash, VISA, Discover, MasterCard, and American Express. We also accept Care Credit.

If you do not have insurance or are covered under an insurance policy that we do not contract with, payment is due in full at the time of service.

In the event that a personal check is returned to us by the bank, there is a $50.00 office fee along with the bank fee that has been incurred as a result of the returned check. The total amount due is required within 10 days of office notification. Restitution may be made in cash, credit card, or bank check. Personal checks will no longer be accepted. If restitution is not made with the required 10 days, the matter will be transferred to the local Magisterial District Judge for legal proceedings.

Patient statements are mailed on a 4 week cycle. Full payment is due within 15 days of statement receipt. If you are unable to pay the balance in its entirety, please contact the office to make payment arrangements.

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**INSURANCES:** We are contracted with a variety of health insurance plans.

If you are covered under health insurance with whom we are contracted, our Billing Department will submit your claim. If the insurance information provided is not accurate, the charges will be turned over to you for payment.

All patients are required to have knowledge of their health insurance. If you have coverage under more than one insurance, it is your responsibility to know which plan is first. If your plan requires that you obtain a referral from your PCP in order to be seen and have the visit paid, it is your responsibility to bring said referral to your appointment. If you fail to provide the referral, you may be asked to reschedule or sign a statement accepting financial responsibility for the service in the event that you are unable to procure the required referral.

**RELEASE OF MEDICAL RECORDS:** Medical records will be released only after the proper forms are signed. Your medical record can be released to you or to another health care provider. Federal law allows 30 days for this action. We will be prompt in forwarding requested records once the required signed forms are received. There will be a charge for any file that is requested more than once.

**PATIENT RESPONSIBILITY:** Regardless of insurance, payment remains your responsibility. All balances that reach 90 days past due will be sent to an outside collection agency. You will be responsible for all collection fees, interest, and/or legal fees incurred and waive all confidentiality due to public records. A 25-35% collection fee (determined by the age of the account) will be added to all accounts sent to an outside agency. All balances must be paid in full prior to any future appointments.

If you have any questions regarding the above listed policies, please feel free to ask or call 717/637-1919.

**PATIENT SIGNATURE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DATE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_