OMNI EYE SERVICES

Payment Policy

Patients with insurance coverage that Omni Eye Services participates:

Omni Eye Services participates with most insurance companies, but each plan varies by employer and insured, please know your plan. Co-payments will be due and payable at the time of your office visit. Deductible and/ or other balances that are your responsibility will be billed to you once the amount is determined. If you are a member of an HMO, you are required by your plan to obtain a referral prior to your specialty examination here. *If your plan requires a referral and you have not obtained one, your examination will need to be rescheduled.*

Patients who have insurance that we do not participate with:

As a courtesy, we will bill your insurance for the services rendered. If we do not obtain a payment from your insurance company within 30 days, you will be responsible for immediate payment. Since we do not participate with your insurance, we will not contact your insurance if your claim is not paid.

Patients who are not covered by insurance or who fail to provide accurate insurance information:

We require payment at the time service is rendered. Please contact the physician and/ or the office manager to discuss a payment plan if you can not pay in full at this visit.

Additional fees:

Our fees are for medical services only for which we may have contracted with your insurance carrier. Additional fees for administrative services apply. Such fees may include but are not limited to fees for medical records as allowed by law, fees for non-covered services, and fees for completion of disability forms or other similar paperwork you request we complete.

All unpaid patient balances will be charged 1.5% interest per month beginning 30 days from the date the balance becomes your responsibility.

I authorize the release of information to determine liability for payment and or to obtain reimbursement. I understand that if my account is not paid directly, I am responsible for the full amount and may be charged all costs including attorney fees incurred with collection of the amount due.

I authorize the release of any medical information necessary to process claims and the release of payment to Omni Eye Services or the physician rendering services.

Patient's Signature:_____**Date:** _____

Insured's Signature:_____**Date:** _____