



**University Eye Specialists, P.C.'s Financial Policy Statement**

**Insurance Billing:** If you have insurance we do not participate with, we will gladly submit a claim for you. It is your responsibility to update the office with changes in your insurance. You will be charged for all non-covered services. If we do not participate with your insurance then you are responsible for all charges at time of service.

**Medicare:** Medicare does not pay for some services, including many things they consider to be "preventive" or "screening". The fact Medicare does not pay for a particular service does not mean that it is not medically necessary. Many services Medicare does not pay for are medically necessary. An Advanced Beneficiary Notice, ABN explaining the charge(s) and fee(s) will be discussed with you for signing before the service is rendered. By signing the ABN, you agree to be personally and fully responsible for payment.

**Co-payments:** All co-payments are due at check-in. If you have questions about how much your co-payment is or which services do or do not have a co-payment please contact your insurance company.

**Deductible:** All deductible amounts are due at time of service. This out of pocket amount resets every plan year. Please be mindful of how much of your deductible you have remaining. Once your deductible has been met you may still be responsible for co-insurance. This is generally a percentage, but may be a set fee. If you have questions about your deductible or co-insurance please contact your insurance company. All deductible and co-insurance amounts are due at time of service.

**Appointment Cancellations:** When we make an appointment for you, we reserve time on our doctors' schedule. As long as your appointment is on the schedule, we cannot use that time for another patient. If you cannot make an appointment, please give us at least 24 hours' notice. Leaving appointments on the schedule that you are not going to show for is both a financial burden to the practice and denies care to other patients. A fee of \$50 will be assessed to all "No-Show" appointments.

**Service Charge:** A 12% service charge will be added to an unpaid balance after 2 billing statement cycles. This charge will continue to accrue monthly until the balance is paid in full. If a bill remains unpaid for greater than 90 days, we will no longer provide eye care for you.

**Refunds:** In the event a patient is due a refund for any type of overpayment it will be mailed in a timely manner. Refund transactions are not posted until we have been paid for all dates of service outstanding. If you have any questions regarding a refund please call our billing department at 1-800-724-0938 or 585-786-2288.

Our physicians and staff work hard to provide you with high quality eye care. Any time a service is rendered, whether it is for an appointment, form completion, referral, prescription refill or some other service, it generates a cost to this practice. It takes time, equipment and supplies to respond to your needs and provide you with eye care. Payment of your bill ensures the availability of our services to you and others.

I have read and understand the above stated policy and agree to the terms and conditions.

I was offered a copy of UES' Financial Policy Statement and declined the copy.

I received a copy of UES' Financial Policy Statement.

Patient or Guardian Signature  
07-27-2016

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07-27-2016