

PATIENT FINANCIAL POLICY

Thank you for choosing Ophthalmology Associates of San Antonio (OASA) for your eye care. We are dedicated to a successful physician-patient relationship with you. Your clear understanding of our Patient Financial Policy is vital to this relationship. Please ask if you have any questions about our fees, our policies, and your payment responsibilities. You are required to notify our office of any changes in your address, telephone number, email, name, and insurance information.

Please **read** each section below and sign at the end, which indicates your acceptance of terms 1-9. A copy of this Patient Financial Policy will be provided to you upon request.

1. **INSURANCE POLICY:** I understand that I am financially responsible and agree to pay all the fees that are not otherwise paid by or billed to my insurance or any other third-party payer. I understand that, if my insurance policy is not active or accepted, I must pay in full for all services rendered. I also understand that if my insurance is accepted, I must pay all applicable insurance copayments, coinsurance, and deductibles at the time of service. I understand that all balances are due upon receipt. Payments may be made by cash, personal check, or credit card. I understand that the charge for a returned check is \$50.00.
2. **REFRACTIONS:** I understand that a refraction is a test which allows my physician to monitor changes in my vision and determine my eyeglasses prescription. It is not covered by most insurance companies, including Medicare. I understand that I will be charged \$85.00 for a refraction which is due at the time of service.
3. **REFERRALS:** I understand that if my insurance company requires a referral from a primary care physician for services from OASA, it is my responsibility to obtain this referral prior to scheduling the appointment. I also understand that I will not be seen by an OASA physician without a current referral on file if one is required.
4. **NO-SHOWS & LATE CANCELLATIONS:** I understand that if I do not show for my appointment or fail to cancel or reschedule my appointment within 24 hours of my scheduled date and time, I will be charged a fee of \$75.00. If I fail to show for my scheduled surgery or fail to cancel or reschedule my surgery within three (3) days of my scheduled surgery date, I will be charged a fee of \$250.00.
5. **ADDITIONAL CHARGES:** I understand that I may be responsible for payment of additional charges including, but not limited to, detailed phone consultations, after-hours phone calls requiring medical decisions or prescriptions, copying and distribution of medical records, prior authorizations, and completion of non-OASA forms.

6. **ASSIGNMENT OF BENEFITS:** I assign all payments, rights, and claims for reimbursement of claims, costs, and expenses allowable under my insurance plan(s), including TriWest Community Care Network (CCN) directly to my provider or practice for services rendered. I understand I will receive a statement for any balance due by me and I agree to make full payment upon receipt of the statement after insurance has met its obligation. I also understand if I receive care under the TriWest CCN, I agree that my provider will receive payment of my medical benefits directly from the Veteran's health plan third party administrator.
7. **OUTSTANDING BALANCES:** I understand that if my account becomes delinquent, and I have not established payment options with OASA, my account will be turned over to a collection agency. I further understand that outstanding balances must be resolved prior to any non-emergency appointments. If you have a financial hardship, please contact our Billing Department to discuss payment options.
8. **WORKERS' COMPENSATION CASES:** I understand that charges for services rendered because of a verified work-related injury will be billed to the workers' compensation carrier as a courtesy if I supply the necessary information to bill the carrier. If my workers' compensation claim is denied, or if I do not provide the necessary information, I will allow OASA to bill my medical insurance carrier, and I will be responsible for any non-covered charges.
9. I understand that I may be given a return appointment in order to follow-up on my ocular status or condition. In the event that, for any reason, I do not keep that return appointment and do not promptly re-schedule, I agree not to hold Ophthalmology Associates of San Antonio, its Physicians, and/or staff responsible for any resulting consequences. Appointments cancelled with less than 24 hour's notice will be charged to your account.

If you have any questions regarding this financial policy, call OASA at (210) 223-5561.

By signing this Patient Financial Policy, I fully agree to terms 1-9 as stated above and their conditions.

Patient Name/Responsible Party (Print)

Signature

Date