EYE PHYSICIANS
OF SUSSEX COUNTY

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Financial Policy

Refraction Charge: A refraction is the process of determining the refractive error of your eyes, or the need for corrective lenses. However, it is considered a non-covered service by Medicare and most insurance companies: thus it is the responsibility of the patient to pay for the refraction charge. This fee is due and payable whether or not you receive a written glasses prescription. Sometimes the change is not significant enough to warrant a new prescription. This payment is due at your visit.

Initials: _____

Co-Payments: I understand that co-payments are due and collected on the day of my appointment.

Insurance Referrals: If my insurance plan requires a referral, I understand it is my responsibility to obtain an updated referral from my Primary Care Provider or Insurance Company and to make sure that Eye Physicians of Sussex County has the referral before my visit. I understand it is my responsibility to keep track of the number of visits I have used and the expiration date and obtain new ones as needed. I understand should I fail to have a valid referral for my visit, and I am seen, I will be considered a self-pay patient and will be responsible for all charges incurred. I understand my insurance company will not cover any visit where a valid referral is not in place.

Insurance Cards: We require you to confirm your insurance is current at each office visit. New patients or existing patients with a change in their insurance information must provide a valid insurance card or temporary print out at the time of the visit. Should I be unable to produce this documentation, I understand I will pay in full at the time of service and submit the claim to my insurance company myself. I understand that in signing below, I am responsible for notifying Eye Physicians of Sussex County of any changes to my insurance. If the insurance information or referral I present at my visit is not correct, I understand I am responsible for all charges.

Patient Responsibility: I will be financially responsible for all non-covered services, deductibles, co-pays, and co-insurances. Payment will also be due at the time of service for any self-pay patient, which includes but does limit those without insurance or an insurance plan that Eye Physicians of Sussex County does not participate in. I understand it is my responsibility to confirm that my insurance plan is accepted by my provider.

Account Balances: I understand that I am ultimately responsible for all fees related to my care. Eye Physicians of Sussex County will file claims for services provided if we are in network with your insurance. I understand that if I fail to make payment for which I am responsible in a timely manner, my account may be turned over for collection and I will be responsible for all costs of collection monies owed, including court costs, collection fees and attorney fees. By signing this form, I authorize the assignment of all health insurance benefits to be paid directly to Eye Physicians of Sussex County. I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine benefits. I have fully read this Financial Policy Authorization and agree to the terms and conditions set forth above. I acknowledge receipt of Eye Physicians of Sussex County Notice of Privacy Practices. I hereby consent to medical care and treatment as deemed necessary and proper by the medical staff of Eye Physicians of Sussex County.

Print Patient Name:_____ **Birthdate:** _____

Signature of Patient/Responsible Party: _____ **Date:** _____