NOTICE OF FINANCIAL POLICY

Please read and sign the following financial policy summary. If you have questions about this Financial Policy, please contact our office at 817-617-7678.

1. Payment is due in full at the time services are rendered. We accept cash, check, and all major credit cards. Post-dated checks will not be accepted by our office.
2. Please be prepared to provide our office with a copy of your insurance card(s) and picture identification every time you visit our practice. Each time you visit our office you may be required to update your personal information such as home address, contact phone numbers, and emergency contact phone numbers. If there are any changes in your insurance, it is your responsibility to notify our office prior to your visit. If the new insurance information is not provided prior to the visit, you could be responsible for charges incurred for any dates of service or treatments prior to the new information being given.
3. If your insurance requires you to pay a co-pay, then you must pay this co-pay at the time of your appointment. Your visit or treatment may be rescheduled if prior authorization from insurance or PCP is required. Payment of unauthorized services is then your responsibility. Fees not covered by your insurance company due to unmet deductibles are due as you leave the office. If this should be the case, we offer payment plans to ensure your treatment does not go unfinished.
4. Physician surgical fees owed are due prior to any surgery performed by the doctor(s) in the various facilities we perform surgery in. This would include any deductible, copay, or coinsurance. Fees quoted by our office for surgery are for the surgeon only. The facility where the operation is performed is responsible for quoting and collecting payment for their fees. It is your responsibility to contact the surgery facility to obtain their fees and make payment arrangement prior to the date of surgery.
5. Financial responsibility for a minor is the responsibility of the accompanying adult unless arrangements have been made prior to the visit.
6. Any PAST DUE BALANCE is required to be paid either by the statement received from our billing office or at the time of your next visit. In the event your account is past due, we will take the necessary steps to collect the debt, and possible referral to a collection agency which could affect your credit record.
7. SELF PAY/CASH PAY POLICY: For patients who are using cash for their office visit, a $300 deposit will be due at the time of service. This is a discounted rate for a new visit which included a dilated fundus ophthalmoscopy and a basic diagnostic optical coherence tomography.
8. INSURED PATIENTS WITH UNMET DEDUCATIBLE: For patients who have not met their insurance deductible, a $300 deposit will be due at the time of service. This deposit will be applied to the actual charges for the visit. If the visit charges exceed $300, the remaining balance will be billed to you. In the event the actual charges are less than $300, the difference will be refunded within 14 days from the last insurance payment.
9. A $25.00 return check fee will be assessed if your check is returned by your bank.
10. Due to the amount of support services associated with FMLA or disability paperwork, we may charge $25.00 for its completion.