Fox Cities Eye Clinic, SC
1301 E Northland Ave, Suite A
Appleton, WI 54911

Financial/Communication Policy

The following are procedural policies of Fox Cities Eye Clinic, SC. (FCEC) Review and signature of these policies are required before services can be provided.

Patient Communication: Confidential messages may be left on your voicemail or answering machine at the preferred number(s) you have provided to FCEC or with a friend or family member who answers the telephone at one of the preferred number or at your residence. Such messages may include, without limitation, reminders of upcoming scheduled appointments, information regarding your pathology or laboratory tests, billing information, or answers to medical questions you may have inquired about to our staff. FCEC may also communicate with you via e-mail, text message, or letter to your home address provided such method complies with applicable HIPAA communication standards. You understand that you are not required to agree to this provision in order to receive treatment.

Insurance Filing: As a courtesy we will bill your insurance company for charges incurred at our clinic. Please remember your health insurance is a contract between you and your insurance company. If your insurance deems a service to be not covered by your insurance plan you will be responsible for the balance of this service and you expressly agree to pay for such non-covered services. Claims not paid by your insurance carrier within 60 days will be considered a non-covered service. We will submit information on your behalf to your insurance company to receive payment. Benefits should be paid directly to FCEC from your insurance company. I hereby assign to FCEC all my rights and claims for reimbursement under by health insurance policy. I agree to provide information as needed to establish my eligibility for such benefits.

Copays: All copays are due at time of service prior to seeing the doctors. Deductible amounts may be collected as well. If you are unable to pay for copays or deductibles at the time of service, FCEC reserves the option to reschedule your visit.

Bad Debt, Bankruptcy and Delinquent Accounts: I realize that if my account is in bad debt or bankruptcy status, I will be required to pay $250.00 (cash or credit card only) prior to my scheduled appointment. This payment will serve as down payment toward services to be rendered at the future encounter. If, after the provider has billed for services and/or the insurance has responded, the practice determines that I do not owe the $250.00 for the current encounter (and if I am not currently under bankruptcy or any other insolvency protection from collection on past debt) FCEC will review my account to see if I owe a balance on any other recent encounters or if I owe anything to Financial Control Solutions, FCEC's collection agency. If it is determined that I do owe on past balances and am not protected from collection by applicable law, FCEC will apply the remaining amount towards such amounts owed. If I owe less than what was overpaid on the account a refund will be issued to me for the appropriate amount. I understand that if my account is sent to collections, FCEC may choose to dismiss me as a patient from the practice. If I pay my past due account in full with Financial Control Solutions, FCEC will still require a $250 down payment at all future visits.

Non-sufficient Funds: A $35.00 charge will be added to your account for any non-sufficient funds notice from the bank. If your account is sent to collections and we have to litigate in court, your visit(s) with our office may become a matter of public record.

No Show Appointments: FCEC reserves the right to charge you $75.00 for any no show appointment.

New Patient No Show Policy: I understand if I no show or cancel my appointment with less than a 24-hour notice FCEC will allow me to reschedule an appointment 1 additional time, if I have a no show or cancel with less than a 24-hour notice a second time FCEC will not reschedule future appointments for me.

Medicaid Insurance Coverage: (THIS SECTION MUST BE COMPLETED BY ALL PATIENTS):

At this time I, _____certify that I (DO) OR (DO NOT) have **State Medicaid** Health Insurance Coverage.
Print Name *Circle One*

If we find at a later time that you did not provide accurate information above, you will be responsible for the balance of the charges incurred. It is your responsibility to inform our office if you acquire any type of Medicaid coverage at a later time. If you don't provide the updated information to our office you may be responsible for the balance of your bill. FCEC is not contracted with all Medicaid insurances. You will be responsible for the full amount of services provided to you.

Non-insured Patients: Non-insured patients will be charged a $250 down payment on the date of service. These funds will be applied to the services provided that day. These fees serve as a down payment and additional payment may be required. Final charges will be determined after the provider sees the patient. A statement will be mailed to you and the balance will be due within 15 days from the date of the statement.

X_____ _____ _____/____/_____Until Revoked
Signature of Patient or Legal Guardian *Relationship to Patient* *Date*

DOB:_____