OPHTHALMIC ASSOCIATES

Patient Financial Agreement

1. Insurance and Billing Acknowledgment

I understand that OA will bill my medical insurance as a courtesy. I am responsible for providing current, valid insurance and personal information at each visit. If my insurance coverage is inactive or does not cover the services, I am financially responsible for all charges. I acknowledge that OA does **not** bill vision insurance at all (e.g., VSP).

1.1 Copayments, Deductibles & Non-Covered Services

I agree to pay all co-payments and deductibles at the time of service. If OA is out-of-network with my insurance, I understand I will be billed for the full difference between OA's charges and what the insurance approves.

1.2 Medical insurance contract

I understand that my medical insurance contract is between me and my insurance company. OA is not party to this contract and will not be involved in any disputes that may arise, unless medical information is required.

1.3 Surgery and In-Office Procedure Payments

I understand that Cataract surgery includes the standard intraocular lens. If I choose instead to have a multifocal or specialty lens, I agree to pay 50% of the cost of the specialty or multifocal lenses on the day of my cataract surgery evaluation, and the remaining 50% at least twenty-four (24) hours prior to surgery. I understand that a deposit and pre-authorization is required for in-office procedures prior to the appointment.

2. Self-Pay Terms (Uninsured Patients)

I agree to pay in full for the applicable office visit prior to receiving services and to settle any remaining balance before leaving the office on the same day. Any additional charges for testing will be discussed with me beforehand, and I have the right to inquire about the cost of any test before it is performed.

3. Refractions

I understand that the contract with my medical insurance may require me to pay for my refraction on the date of service.

4. Late Balances and Collections; No-Show and Cancellation Fees

Balances not paid within sixty (60) days are considered overdue. Balances not paid within ninety (90) days may be referred to collections. I understand that non-emergency care may be postponed if I have unresolved past-due balances. I agree to provide at least 24 hours' notice for appointment cancellations. I understand I will be charged $25 for missed office visits and $200 for missed in-office procedures.

5. Refunds and Returned Payments

I understand fees may be applied for returned checks or failed transactions. Refunds for overpayments will be issued monthly by paper check.

6. Consent to Contact and Payment Terms

I authorize OA to contact me regarding billing or balances via phone, email, or mail. I agree that OA may use third-party services for collections if necessary. As a patient of Ophthalmic Associates (OA), I acknowledge that I have received, read, and understand the **Patient Finance Policy**. I agree to the above stated terms regarding my financial responsibility for the medical services provided by OA.

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Patient/Guardian Name (Printed) **Date**