THE Eye Center

ROCKVILLE PIKE
1801 Rockville Pike, #103
Rockville, MD 20852
240-221-3134 Fax

301-279-9696
www.theeyecenterinc.com

SHADY GROVE
15005 Shady Grove Rd., #100
Rockville, MD 20850
301-251-5454 Fax

Financial Policy Statement

Welcome To the Eye Center Inc. Thank you for choosing us as your healthcare provider. Your clear understanding of our financial policy is important to our professional relationship.

Fees and Payment Policy: Deductible and Insurance co-payments are due at the time of service. We will submit to your primary carrier and as a **courtesy** we will submit to your secondary carrier if necessary. We **WILL NOT SUBMIT TO TERTIARY** plan. If we are not provided with the correct information for your plan or your insurance neglect to pay within 60 days, all charges are your responsibility. Your insurance is a contract between you, your employer and the insurance company. We are not party to that contract. Before your visit, contact your insurance company to verify that we are participants in your plan, and the services you intend to receive are covered. In order for us to file a claim, you must present a CURRENT copy of your insurance at each visit and communicate changes in your personal information. Not all services are a covered benefit in all policies, so it is very important that you understand the provisions of your individual policy.

Referrals: It is your responsibility to know if and when a referral is needed. Failure to provide the proper referral for the scheduled visit WILL RESULT in the appointment cancellation. If you wish to be seen without a referral, you must sign a waiver and pay in full at the time of service. If the proper referral is presented after the visit, the patient will be reimbursed by the office after the insurance payment has been received.

Please Note: Each visit is documented in your medical record and a diagnosis is made by the provider. Diagnoses are made based on medical information, not based on coverage by insurance companies. To request a diagnosis change solely for the purpose of securing reimbursement from an insurance carrier is considered insurance fraud and will not be done by our office. If you wish to use a routine eye care benefit, it is your responsibility to convey this to the doctor before the conclusion of your appointment.

MVA form: $10 fee is charged for completion on the MVA form outside of an appointment.

Returned Check Charge: Non-Sufficient Funds (NSF) checks are subject to a $50.00 fee (in addition to fees from your bank).
Cancellation Policy: Should a patient need to cancel/reschedule a surgical appointment a minimum of 5 business days must be given. If a surgery patient is a no-show, has eaten or is late and the surgery has to be rescheduled a $100 fee will be applied to the patient's account. $50 will be charged for no-show on a regular appointment.
I have read and understand the financial policy statement and agree to comply and accept responsibility for any payment that becomes due as outlined the financial policy.

Patient signature: _____ Date: _____

Print Patient Name:_____ Date of Birth:_____

Thank you for choosing the Eye Center Inc., a progressive healthcare team dedicated to excellence in patient care.