NTEC
North Texas Eye Center

Dr. Lewis J. Frazee, M.D. - Dr. Ellen Ngo, M.D. - Dr. James Passmore, M.D.

PATIENT FINANCIAL RESPONSIBILITY

Recognizing the need for patients to understand what is expected regarding payment of medical services, we have established our financial policy. Some of these items are required by law. It is our goal to remain sensitive to our patients' needs while providing quality medical care, and we encourage you to contact our office if a problem should arise regarding your account.

1. **All co-pays and co-insurance required by your insurance company must be paid at the time services are rendered.** We accept cash, checks, and Visa, MasterCard, Discover and American Express cards. There is a $25.00 service charge on all returned checks. After receiving a returned check, North Texas Eye Center will only accept cash, money order, or credit card.

2. **It is the patient's responsibility to be aware of the contract benefits of his/her insurance carrier or any co-payment, deductible or referral obligation.** If your insurance requires referrals for full benefits to be paid, it is your responsibility to verify that the referrals are in place prior to your visit. Additionally, I hereby waive all indemnity from this responsibility that may otherwise be afforded to me by my insurance carriers. Accordingly, I agree to pay for all charges not covered by my insurance carriers relating to absent, incorrect, improper, expired, or otherwise unacceptable referrals. I understand that I am responsible for payment of fees for any specialized test requested by my physician for diagnostic purposes if my Medicare or insurance company denies payment of such diagnostic test for any reason.

3. **Our facility will file both primary and secondary insurance claims for medical services rendered.** Claims for a third insurance contract will not be filed unless required by our contract with the carrier. We cannot file claims correctly without accurate information from you. Proof of insurance must be presented at each visit. I understand that by signing this form that I am requesting my insurance company to pay claims directly to this office

4. **If you do not have insurance,** payment in full is expected at the time of service unless financial arrangements have been made in advance with our billing department.

5. **You will receive a statement from our office within 45 days of your insurance company's response.** If you are dissatisfied with their payment, please contact your insurance carrier. Payment of the patient's portion of the balance is due upon receipt of the statement. Failure to comply may result in the involvement of a collection agency. The only exclusion to this policy are HMOs and PPOs where except for deductibles and co-payments, balance billing is prohibited.

6. **We are participating providers for Medicare.** This means that we must accept Medicare's allowed charge for the services rendered. Medicare will pay 80% of the approved amount. The patient is responsible for the remaining 20%, plus any out-of-pocket deductible. We will write off the difference between what we charge and what Medicare approves. If you have secondary insurance, we will submit the claim for the remaining balance after Medicare has paid. Please remember that although we accept assignment for Medicare, the patient, by federal law, is responsible for any portion of the approved amount not paid by Medicare or a secondary insurance company.

7. **Responsibility for payment for services rendered to the child/children of divorced or separated parents** rests with the parent who seeks treatment. Any court ordered judgment must be between the individuals involved, without including our facility.

8. **In the unlikely event your payment is returned to us unpaid,** we may elect to re-present your payment, either electronically or by paper draft, to your financial institution up to two more times. We may also collect a return processing charge by the same means, in an amount not to exceed that permitted by state law.

9. **We offer contact lens services.** I understand that in order to get a contact lens prescription with a routine eye examination it will require a contact lenses fitting. I understand that there is an additional charge for the contact lens fitting. Furthermore, I understand that I must keep the container in which my contact lenses were delivered to me in. Doctors Frazee, Passmore and Ngo cannot return defective lenses without it. Financial obligation for ordered lenses is initiated at the time the order is placed.

It is our hope that you will find this information helpful. If you have questions, please speak with our billing staff at (972) 867-7777 option 7

Signed: _____ Date: ____/____/____