



## Financial Policy

Thank you for choosing Optometric Physicians Northwest. We are dedicated to providing an excellent eye health care experience.

### **Insurance**

**Patients are expected to bring all their current medical insurance and vision plan cards to each visit.**

OPNW participates with many health and vision plans. As a courtesy, we will file claims with these companies. We will only bill the insurances that are presented at the time of service (primary and secondary only; any tertiary plans are patient's responsibility to bill). Your insurance contract is an agreement between you and your insurance carrier. It is ultimately your responsibility to know your insurance coverage.

### **Understanding Your Vision Plan and Medical Insurance**

There are two types of health insurance that may help you pay for your eye care services and products. You may have both and our practice accepts both. These guidelines are used to anticipate your visit and minimize any surprises.

#### **Vision Care Plans (VSP, NBN)**

Vision plans only cover routine vision screenings to determine a prescription and may have a hardware benefit that can be used for frames and lenses, or contact lenses. This evaluation is not comprehensive and does not include fees associated with a contact lens evaluation or materials. Vision plans also do not cover testing to diagnose, evaluate, or treat medical issues.

#### **Medical Insurance (Blue Cross, Regence, Premera, Aetna, Cigna, Medicare)**

Insurance must be used if a medical condition exists such as (but not limited to) cataracts, glaucoma, dry eye, diabetes, high blood pressure, or any other condition related to eye health. This exam may include further testing beyond a routine screening. In the case of a diabetic exam, it will be billed to medical without exception.

It may cover a large portion of a medical exam where a medical diagnosis is present but will not cover the refraction (non-medical). We will bill all services but the **refraction fee of \$70 must be collected at time of service.**

Office copays vary and may be more or less for medical vs. vision. We are bound by the insurance policies to bill the copay that applies to the office visit. We will try our best to obtain information regarding your plan benefits in advance but it is ultimately your responsibility to know your plan details. If some fees are not paid by your plan, we will bill you for any unpaid balances as allowed by the insurance contract; this may take for your plan months to process the claims.

In the case of a minor not accompanied by a legal guardian, items not covered by insurance must still be paid at the time of service.

**While we may estimate your financial responsibility, it is your insurance company that makes the final determination regarding your eligibility and benefits.**

## **About Our Services**

We offer a 20% time of service discount at the time of your appointment for comprehensive or medical exams in which insurance is not billed. We also extend this discount if time of service payment is made and you submit a claim for reimbursement from your insurance company.

Payment is due at the time of service for all amounts known not to be covered by your insurance. These amounts can include copayments and refraction fees. We accept cash, personal checks, Visa, MasterCard, Discover, AMEX, and Apple Pay in the office. If you need to make payments we do offer Care Credit, which offers zero interest options over six or more months. **More information is available upon request.**

## **Refractions**

Our eye exams have two portions, the eye health check and the refraction. The refraction is also called a vision test. This determines your ability to see an object at a specific distance. The test involves looking through various lenses to read letters or recognize symbols on a wall chart (during this process your technician will ask “Is one better or two”). This test is performed as part of an eye exam to determine whether an individual has normal vision. It is also used to determine the prescription for glasses or contact lenses. This test must be done as part of your exam in order to maintain a current prescription. **Most insurance plans, including Medicare, do not pay for refractions and you will be asked to pay the \$70 fee at the time of your appointment.**

## **Glasses and Contact Lenses**

When eyewear and contact lenses are ordered, full payment is due at the time of order. If you currently wear or are interested in wearing contacts, there are separate charges for the contact lens exam for current wearers and fitting for new wearers which must be paid at the time of service, in order to keep a current contact prescription.

## **Delinquent Accounts**

We charge a 1.5% interest after 45 days. We also refer delinquent past due accounts to an outside collection agency. An account that is referred to a collection agency will result in termination of eye care services from our office. We will be available for 30 days after the account is transferred for emergency care only; this is to allow patients to find another eye care provider.

## **Late Cancelled/Missed Appointments**

Your eye care appointment is a reservation so we can take care of you as an individual. We allow time that gives our patients personalized concierge service and time with your doctor and eye care team. Therefore we rely on you to keep your reserved appointment time. We require at least 24 hours' notice to change any appointment. A \$50 fee will be charged for any missed appointments. We understand emergencies come up and allow a one-time grace that will be applied to your account upon making and keeping the rescheduled appointment.

**Patient Agreement**

I understand and agree that I am financially responsible for all charges for any and all services rendered. This includes any medical service, routine exam, refraction, testing, contact lens services and any other screening ordered by the doctor or staff.

I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balances.

I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full.

If I am a Medicare patient, I understand that I need to provide the office both my Medicare ID card and secondary ID card if applicable. If the office does not have the proper information for a secondary insurance, the secondary will not be billed. It will be my responsibility to pay the balance and then file a claim with the secondary plan for potential reimbursement.

By signing this form I consent to the use and disclosure of protected health information about me for treatment, payment, and health care operations, and/or as required by law. I have the right to revoke this Consent in writing signed by me. However such revocation shall not affect any disclosures already made in compliance with my prior consent. This form is to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

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Printed Name

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Parent or Legal Guardian Signature

Date