Tauber Eye Center Financial Policy

To better serve you, we ask that you provide payment authorization by credit card / electronic bank account debit to cover outstanding *Patient Responsibility* balances. This includes balances for deductible, co-payments and non-covered services (Medicare beneficiaries and Workman's Compensation excepted).

We accept Discover, Mastercard, Visa and Care Credit in addition to cash and personal checks. $30 charge will be added for check payments rejected by your bank for any reason.

Tauber Eye Center contracts with several insurance companies with "in-network" status.

- We will assist you with pre-certification for procedures we recommend.
- Insurance companies require us to collect your co-payment at the time of service.
- Our office will file the claim with your insurance company. After your insurance company processes the claim (18- 45 days), you will receive an Explanation of Benefits (EOB) form showing your balance (Patient Responsibility). You will receive one statement from us
- If your balance is unpaid within 30 days, your account will automatically be charged for the balance, and a receipt will be sent to you with an updated second statement.
- For large balances, you may contact our Billing Dept to arrange for a payment plan, which must be confirmed in writing.

Cancellation Policy

Not showing up for a scheduled appointment inconveniences our office and other patients. If it is necessary to cancel your scheduled appointment, we require that you provide 24 hour notice of the cancellation. Early cancellation will allow another patient the opportunity to receive an appointment in a timely manner. Cancelling your appointment can be done in two different ways. You can cancel your appointment when you receive the automated reminder by following the instructions given. The second way is to call our office at 816-531-9100. Failure to cancel at least 24 hours prior to a scheduled appointment will be considered as a "no show". No-show charges will not be billed to insurance, but directly to the patient or guarantor.

- As a courtesy, there will be no charge for one no-show appointment within a calendar year.
- Should there be a second "no-show," there will be a $25 missed visit fee charged.
- In the event of a third no-show, you will be billed $120 for the cost of a complete office visit.

- **It is your responsibility to verify that the care you receive is covered by your insurance.**
- **I understand these policies and accept responsibility for payment of my account.**
- **I understand that if my account becomes delinquent, it will be referred to a collection agency and a 30% collection fee will be added to any outstanding balance.**

I understand that if I refuse to provide checking/credit card information for billing that a $20 fee will be added for each additional statement that is sent out.

_____ _____ _____

Patient / Responsible Party name signature Date

Authorization Agreement for Pre-Authorized Payment

This authorization is for the Patient Responsibility portion of your bill. For contracted insurance, this will be the amount remaining after insurance payment and adjustment.

COPY OF FORM OF PAYMENT – CREDIT CARD OR CHECK

□ Discover □ Mastercard □ Visa

Card # _____EXP ____/____ Security Code_____

I authorize Tauber Eye Center to keep my signature on file, and to charge the credit card or bank account identified above for the balance of charges not paid by my insurance company for services I received from Tauber Eye Center.

- At any time, I may pay my account in full to prevent this authorization from being activated.
- I will be notified by statement before charges are sent to my credit card or bank account.
- I understand that this form is valid for one year unless I cancel this authorization in writing and notify Tauber Eye Center of such cancellation.

_____ _____

Patient / Responsible Party signature Date