Bellingham Bay Ophthalmology PLLC Financial Policy

James M. Kim, M.D.

Thank you for choosing Bellingham Bay Ophthalmology PLLC. Our doctors are committed to providing you with the highest quality of eye care. To keep you informed of our current office and financial policies, please read this page carefully and sign the bottom acknowledging your understanding of our office and financial policies prior to treatment.

General Office Policies:
All new patients will need to **provide valid photo ID and a current insurance card.** Please note that we are unable to file insurance for your services unless we have current insurance information. Each patient will also complete a patient information form and medical history form. We will update your demographic information annually, but we will verify everything is current at each visit. Please notify us if you move or change your phone number.

Referrals:
It is the **patient's responsibility** to request a referral from your primary care physician if your insurance requires one. We will arrange any pre-authorization or referrals for you if your **surgery** is scheduled. **We may need to reschedule your appointment if you arrive without the proper referral and/or current insurance cards.**

Reminder calls: For Each appointment you will receive a reminder phone call one business day prior to your appointment. If granted permission, we will leave a message on the number provided. **Please INITIAL box below.**

Please Initial

☐ I consent to information regarding MY OWN, (or my child's, if under the age of 18), test results or detailed appointment reminders/instructions be left on my voicemail or answering machine. I understand that sensitive information will be excluded.

Insurance:

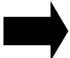
Your insurance policy is a contract between you and your insurance company. Bellingham Bay Ophthalmology PLLC is contracted with most major medical insurance companies and we will bill your insurance plan for you, provided that you have given us correct and current information. Please note we are **not contracted providers for many vision insurance companies (Superior Vision & VSP are examples). It is the patient's responsibility to check with their insurance company PRIOR to their appointment regarding coverage, referrals, deductibles, eligibility questions and to determine whether our doctors are participating or non-participating providers.**

All copays are due prior to seeing the doctor, as per the contract with your insurance company. Please be aware that some services may be considered a non-covered service or not medically necessary under your insurance plan. Once we have billed your insurance company, it is the patient's responsibility to follow up with them regarding outstanding claims. The patient/guarantor/guardian is ultimately responsible for payment for services provided.

Medicare Patients ONLY:

The **REFRACTION** portion of your exam (the test to determine your glasses prescription) is **never** (and has never been) covered by Medicare. You will be asked to pay this portion of the exam at the time of service if your supplement or Medicare Advantage Plan does not cover the refraction. This also applies to medications and supplies dispensed from our office. The refraction fee is $90.00. Please **INITIAL** the box below.

Please Initial



☐ I understand and agree that I am responsible for the refraction fee of $90.00 if denied by insurance.

I request that payment of authorized Medicare benefits be made either to myself or on my behalf to Bellingham Bay Ophthalmology PLLC for any services furnished to me, in lieu of my signature form HCFA 1500. I authorize any holder of medical information about me to release CMS/Noridian Medicare any information needed to determine these benefits payable for related services.

Please Sign

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Signature as it appears on Medicare Card

TURN OVER

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Recheck Policy:

If you have concerns with your glasses or contact lens prescription, we will recheck the refraction test to confirm the accuracy of the prescription. This will be done at no charge provided it is **WITHIN 60 DAYS** of the date on the prescription.

Cancellation Policy:

I understand that no-shows and a late-cancel appointment may result in a fee of $40.00, and repeated occurrences may result in dismissal of the practice. I understand that I am directly responsible for payment of the fee and that my insurance will not be billed.

Payment Policy:

For patients with no insurance, we request payment in full at the time of service. We are pleased to be able to offer a 10% discount if you pay in full at the time of service (private pay only). If you are unable to pay in full, we will ask that you make payment arrangements with our accounts manager at the time you schedule your appointment. We accept cash, check, Visa, MasterCard, Discover, debit cards and Care Credit.

All copays are due at the time of service. NSF checks will be assessed with a $25.00 fee. Delinquent accounts will be referred to Physicians and Dentist Credit Bureau may result in termination of care at our office.

Notice of Privacy Policies: Please note that Bellingham Bay Ophthalmology PLLC has a responsibility to protect the privacy of your health care information and to post and provide a Notice of Privacy Practices that describes how your health care information may be used and disclosed, how you can access your health care information, and whom to contact if you have any questions, concerns, or complaints. We may change the Notice of Privacy Practices at any time and you may contact
Bellingham Bay Ophthalmology PLLC at 360-647-7750 to obtain a current copy or to ask questions.

I have read the above Financial Policy and understand and agree to its terms. I hereby authorize my insurance benefits to be paid directly to Bellingham Bay Ophthalmology PLLC. I am financially responsible for any balance due because of co-pay, deductible, referral or authorization not obtained prior to visit, or incorrect or lapsed insurance information. I authorize the release of my medical information as required by the insurance company(ies) to process claims.

Signature (or Guardian's signature): ____ Date: ___________________