Ophthalmic Physicians Incorporated

Office Policy & Notice

Thank you for choosing Ophthalmic Physicians Incorporated (OPI). We are committed to building a successful relationship with every patient. Your clear understanding of this agreement is essential to the success of this relationship. If you have any questions about our fees, policies, or your responsibilities, please do not hesitate to contact us.

Insurance: We participate in many insurance plans, including Medicare. Please be aware that your insurance reflects a contract between you and your insurance company. Not all services are a covered benefit in all policies, so it is imperative that you understand the provisions of your individual policy. While our staff will make every effort to assist you in understanding your benefits, OPI cannot be held responsible for knowing whether a particular service is covered or not. Ultimately, all financial liability lies with the patient/guarantor.

Billing: If we are a participating provider for your insurance, we will submit your claim as a courtesy and assist you in any way we reasonably can to help get your claim paid. For us to file your claim, you must present a current copy of your insurance card(s) at each visit and communicate changes in your personal information and/or coverage(s). All copays are due at the time of service. This arrangement is part of your contract with your insurance company.

Payments: Payments may be made with cash, check, or credit card. Payment plans are also available through our billing department and/or CareCredit®. Although fees are due at the time of service, we will do our best to help you structure an affordable payment plan for your care.

Referrals and Pre-authorizations: We are a specialist's office. If your insurance company requires a referral and/or preauthorization, we will do our best to assist you with this process. Ultimately, you are responsible for making sure that the referral and/or preauthorization is obtained. Failure to do so may result in a significantly lower payment from the insurance company, and the outstanding balance will be your responsibility.

Statements: After we receive the explanation of benefits from your insurance company, any remaining balance will be due and payable to our office within 30 days. Instances of overpayment will be refunded to you per the terms of our Refund Policy (see below).

Collections: Our office sends two statements to anyone with a balance due. If payment is not made on your account, we will make one phone call and send one letter. If no resolution can be made, your account will be sent to a collection agency, and you may be discharged from the practice for non-payment.

Returned Check Charge: Non-Sufficient Funds (NSF) checks are subject to a $25.00 fee (in addition to any fees from your bank). You may be placed on a cash only basis following any returned check.

Refunds: Occasionally, a payment made for a service may be covered by your insurance at a different level than we anticipated. In those instances, your overpayment will be applied to your next visit or refunded to you.

Self-Pay Patients: We offer a discount to patients without insurance, patients covered by insurance our office does not participate in, or patients who do not want to submit a claim to their insurance. The discount applies to physician services only and does not apply to any products we sell including but not limited to eyeglasses and contact lenses.

Missed Appointment Charge: We understand that situations arise in which you must cancel your appointment. We kindly ask that you notify our office at least 24 hours in advance if you need to cancel/reschedule an appointment. You may be charged $25 for missed appointments without notification. Patients who repeatedly no show may be dismissed from the practice.

Medical vs. Vision Exams: There are two types of insurances that may help pay for your eye care services and materials - medical and vision. You may have both types of coverage and it may be necessary for us to bill some services to one plan and other services to the other. Benefits are based on a patient's diagnosis. **PLEASE NOTE A DIAGNOSIS CAN NOT BE MODIFIED TO FIT YOUR PLAN'S BENEFIT.**

Minors: The parent or guardian who accompanies the minor is responsible for full payment. Parents are responsible to communicate with each other about treatment and payment issues.

Elective Surgery/Lens Fees: Fees for services not covered by insurance, such as intraocular lens upgrades, must be paid in full no less than 7 days prior to services rendered. An estimate will be provided to you upon scheduling. Unpaid fees will result in deferral of your surgery.

Refractions: A refractive examination is not a covered service by most insurance companies, including Medicare. If you receive a refraction, you will owe $40.00 for this test.

Cooperation: We appreciate your assistance in helping us care for you in an effective manner. We reserve the right to terminate a patient from the practice whenever they may be verbally or physically abusive, refuse to give necessary information, or are non-compliant with ocular instructions, treatment, and advice.

Workers' Compensation: Services provided for treatment of a work-related injury or illness are generally covered by workers' compensation. We will work with your employer and/or workers' compensation carrier to ensure prompt care and payment. If your claim is denied, you will be financially liable for any services provided for treatment of the work-related injury/illness.

Disclosure of Ownership: Dr. Gregory Eippert; Dr. Carrie Happ-Smith; and Dr. Gregory Riffle have a financial ownership in Surgical Care Center.

Notice of Privacy Practices: I hereby acknowledge that a copy of OPI's Notice of Privacy Practices has been made available to me to review and that a copy is available at my request. I hereby consent to the use and disclosure of my protected health information by OPI for the purposes of treatment, payment, and health care operations. Other than myself, I hereby authorize OPI to release and discuss medical information and/or billing information with the individual(s) listed as my emergency contact(s) as necessary. I understand that it is my responsibility to contact OPI should such information change.

I hereby acknowledge that I have read and understand OPI's financial and office policies and agree to be bound by its terms. I also understand that such terms may be amended by the practice at any time.

Print Name: _____ DOB: _____

Signature: _____ Date: _____