Patient Name: _____

Acct #: _____

DOB: _____

IEC BILLING PRACTICES, FINANCIAL POLICY, & HIPAA AUTHORIZATION

BILLING AND REIMBURSEMENT PROCEDURES:

Medical Benefits Authorization: I understand that I am financially responsible for any and all charges not covered by my insurance, Medicare, Medicaid, or other third party payers, including deductibles, co-pays and/or coinsurance amounts. Most medical insurance plans, including Medicare, do not cover Refraction fees. Our office policy is to charge for this procedure in addition to the office visit co-pay and/or deductible. I agree to pay my account regardless of such coverage. If Illinois Eye Center has to take additional steps to collect this account, I agree to pay all costs of collection including court costs and reasonable attorney fees.

In Network Billing: Our office will bill all covered services to a Primary and Secondary Insurance policy. We do not bill to more than two insurance carriers. By giving us your insurance information you authorize our office to request payment be sent directly to us. We will also make reasonable appeals for payment when necessary. Patients will be billed for services according to their insurance coverage and will be notified of their financial responsibility before services are rendered, whenever possible, including but not limited to their co-pay and co-insurance, which is due at the time of service. **Payment for all services is due within 90 days of the services performed.**

Patients Requiring Financial Assistance: IEC offers financial assistance for patients who qualify. Eligibility is determined based on income, family size, and other relevant factors. Applications can be submitted for review and approval.

Charity Care at reduced or no cost to low-income patients: IEC sees the patients of OSF Community Care Clinic at no cost and as a service to the patients in our community.

Private Pay (Uninsured or Non-covered Services): IEC will see patients who are private pay. Before any medical treatments are provided, a consult with a physician with a charge of $50.00 is required and due prior to being seen (either at the front desk or over the phone). Once a treatment plan for your condition has been set, then we will work with the patient for a payment plan that will be required to be kept up to date in order to continue medical services. The original charge will be used towards the cost of treatment.

Patient Balances: If a balance is still due after 30 days, a payment plan with IEC must be made in order to continue medical services. If a payment plan is not put into place and agreed to, your account may be locked from scheduling additional appointments until a payment plan agreement is achieved. If the balance on your account has not been paid, and a payment arrangement has not been set up with our Billing Department, the balance will be forwarded to our collection agency. The patient is responsible for any collection charges, attorney fees, court costs and finance charges that accrue.

Outside Services: Patients may receive additional charges from other medical companies related to the medical treatment rendered at IEC. Those may include lab fees or facility fees from other healthcare institutions and those are the responsibility of the patient.

FTC Consent: I understand that if my doctor finalizes a prescription for glasses or contacts during my visit, I will receive a copy of the prescription on the same day, before leaving. If I decline to take a copy at that time, I can request to have it sent to me via mail or email at any time while the prescription is active. I acknowledge that I have the option to use my prescription to purchase glasses or contacts from the provider of my choice.

HIPAA Privacy Practices Authorization: IEC notice of privacy practices provides information about how we may use and disclose protected health information. The Illinois Eye Center is in compliance with the Health Insurance Portability and Accountability Act of 1996. I acknowledge that I have received a copy of the Illinois Eye Center notice of privacy practices. I give my permission for medical information to be sent to me by phone, mail, or e-mail. I agree that Illinois Eye Center may request and use my prescription medication and durable medical equipment from third-party pharmacy benefit payers; and exchange electronic health record history with other healthcare providers. I may opt out of electronic health record sharing at any time by notifying the front desk staff.

Consent to Electronic Communication: By signing below, I consent to receive communications from Illinois Eye Center via email and text message (SMS), including but not limited to appointment reminders, scheduling updates, notifications of office closures or delays, and promotional or marketing messages. I understand that message and data rates may apply depending on my mobile carrier. I acknowledge that I may revoke this consent at any time by notifying Illinois Eye Center or by following the opt-out instructions included in such communications.

IEC Patient Behavior: At IEC we are committed to providing a safe, respectful, and welcoming environment for all patients, visitors, and staff. To ensure a positive experience with everyone, we ask that patients adhere to the following guidelines:

*Treat all staff, patients, and visitors with kindness and respect.
*Use of appropriate language- threatening, abusive, or discriminatory remarks will not be tolerated.
*Physical or verbal aggression, threats, or any form of harassment will result in immediate removal and possible discharge from the practice.
*Repeated behavior of excessive cancelations or no shows of booked appointments is not permitted.

Failure to comply with this policy may result in warnings, denied services, or permanent dismissal from our clinic.

The patient or responsible party agrees to the Physician's reasonable and customary fee for medical services. By signing this form, you acknowledge financial responsibility and authorize Illinois Eye Center to release any information acquired in the course of your exam or treatment to other physicians, etc for health reasons.

Patient Signature: _____ Date: _____