Pediatric Ophthalmology Associates

Financial Policy

Thank you for selecting Pediatric Ophthalmology Associates for your eye care. The following information outlines financial responsibilities regarding services.

Our Physicians are specialized in Ophthalmology, therefore, we do not accept vision insurance. We do, however, submit claims to medical insurance. You are welcome to ask for a reciept in order for you to submit it to vision insurance for possible reimbursement.

You, the patient, are ultimately responsible for all charges that occur with services provided to you. Our practice is in network with many insurance companies. It is your responsibility to check with your insurance for coverage and participation details.

We will submit insurance claims on your behalf to your primary and secondary insurance. Please be aware that your insurance is a contract between you and them and it is your responsibility to know and understand your insurance plan. It is also your responsibility to understand the Coordination of benefits if you have more than one insurance policy. It is important that we are made aware of all active policys in order to send the claim to the correct primary insurance. Secondary insurance will not pay on a claim that has not been processed by primary first. You will be financially responsible for any claims that are denied due to failure to disclose to us all active insurance policies.

It is your responsibility to:

- Provide our facility with an updated insurance card (Primary And Seconday) upon every visit.
- Be prepared to pay for your co-pay, non-covered services, and balances on your account at each visit.

Failure to provide any of the above may require you to pay in full or reschedule your visit.

If there is a remaining balance due after your insurance pays, you will be billed. If that balance is not paid within 90 days, we will send balances that are outstanding to a collection agency.

Our office will do what we can to assist you in every way. If you have any concerns or questions please call us at 402-399-9400.

I authorize the release of any medical or other information necessary to process claims._____

Initials

Your signature below indicates that you have read and agree to this Financial Policy

_____ _____

Patient/Guardians Signature Date