

Ticho Eye Associates Financial Agreement



Thank you for choosing Ticho Eye Associates to serve your eye care needs. Please read our Financial Agreement completely; if you have any questions, please ask one of our associates for assistance or call our billing team at 708.873.0088.

You will be asked to show the receptionist your current insurance cards each visit. This allows us to verify the information and assist you in collecting the benefits from your insurance company to which you are entitled.

Routine vs. Medical Exam

A routine vision exam is a screening exam which is performed as a healthy visit. It is most frequently requested by patients to determine the need for corrective lenses. **Not all insurances cover screening exams or offer of vision benefit.** It is your responsibility to know if you have this benefit and how often it may be available. You will be responsible for payment if your vision exam is not covered. A medical exam is billed to your medical insurance with the symptom or condition that was present on the day of the visit.

Refraction

This is a test to determine if you need an eyeglass prescription. Unfortunately, most insurance companies do not cover this test. The fee for this test is \$40.00, and it is due at the time of service.

Insurance Claims

Please bring your insurance cards to every visit in order to accurately bill your insurance company. We require that you provide accurate and current insurance information, including primary and secondary insurance. Failure to provide complete insurance information will result in the patient's responsibility for the entire bill. Although we may estimate what your insurance company possibly will pay, the insurance company makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. **Although our practice may be contracted with your insurance company, we may not be a participating provider with your plan. It is ultimately your responsibility to understand the terms and conditions of your insurance plan.** Check with your insurance company to be sure we participate in your plan. If we do not participate in your plan, you will be responsible for full payment.

Vision Plans - EyeMed Only

Doctors Strako, Haddad, and Bandemer accept EyeMed's vision plan. Please check with your plan to see if we are members, as there are some EyeMed plans with which we are not in network. If we are not in network, services are payable at the time of service.

Co-Payments

Patients are expected to pay **AT THE TIME OF SERVICE** all amounts known not to be covered by the insurance company. These amounts include copayments, coinsurance, and/ or deductibles. Payment may be made by cash, check, and/or credit card. **A fee of \$10.00** will be added if copay is not paid at the time of service.

Patients without Insurance Coverage

Self-pay accounts are for patients without insurance coverage, patients covered by insurance plans in which the office does not participate, or patients without any insurance card on file with us. It is always the patient's responsibility to know if our office participates in their plan. If you come for an office visit and we do not participate with your insurance company, we assume you will decide to see us as an out-of-network provider.

Ticho Eye Associates offers discounted self-pay fees to patients who are not covered under any insurance plan. The discount is offered as a courtesy because we do not have to send statements or track payment since payment in full is expected **AT THE TIME OF SERVICE**. The discount applies only to physician services and does not apply to any products we sell, including but not limited to eyeglasses and contact lenses.

If you have extenuating circumstances, please ask to speak with a billing team member to discuss a mutually agreeable payment plan.

Payment Plan

Extended payment arrangements for established patients may be available for larger balances. Please ask to speak with a billing coordinator to discuss a mutually agreeable payment plan. If you pay cash, please ask for a receipt so you will have a record of your payment.

Care Credit is a financing option that is available for patients with balances over \$200.

****We do not accept attorney letters or contingency payments.***

Collections

If you fail to pay on time and Ticho Eye Associates refers your account to a third party for collection, a collection fee of 33.3% will be assessed, due, and owing at the time of the referral to the third party.

Workers' Compensation

In the case of worker's compensation, you must obtain the **claim number, phone number, contact person, name, and address of the insurance carrier** before your visit. If this information is not provided, you will be asked to reschedule your appointment or pay for your visit at the time of service.

Return checks

The charge for a returned check is \$25, payable only by cash or credit card. This charge will be applied to your account. In addition to the insufficient funds amount, you may be placed on a cash-only basis.

Minors The parent(s) or guardian(s) accompanying the minor is responsible for full payment and will receive the billing statements. If someone other than the legal guardian is accompanying the minor patient, a permission form or a letter in writing is required for the accompanying adult to be present.

Outstanding Balances

If your account becomes delinquent and you have not established or met payment options with our billing department, your account will be turned over to a collection agency. Outstanding balances must be resolved before any non-emergency appointments. You will have 30 days to pay your balance using a credit card, cash,

or check method. Any balances due after 30 days will be charged to the credit card on file. Credit Cards on File will be used to pay account balances after insurance adjudication. If you have a financial hardship, or if you are unable to pay your bill in its entirety, please contact our billing department to discuss payment options. Our staff is always available to listen and help.

This Financial Policy helps the office provide quality care to our valued patients. If you have any questions or need clarification of any of the policies, please feel free to contact us at 708.873.0088.

Medical Records

A completed medical record request form is required to obtain your medical records. Patients, attorneys, and insurance companies requesting copies of medical records will be charged in accordance with Illinois State Law. By law, we have 30 days to complete your request; however, we strive to complete your request as quickly as possible.

\$34.72 Handling Fee – Initial fee

\$ 1.30 per page 1-20

\$.87 per page 21-60

\$.43 per page 61-End

- Actual mailing costs (not including handling fees).
- \$10.00 rush fee if records are to be provided within two business days.
- \$20.00 certifying fee (if appropriate)

Additionally, if records are requested to be faxed to another physician's office, the fax number to that physician's office will be required. This service is offered at no charge.

No Show Fee/Cancellation Fee

We kindly ask for a 24-hour notice of cancellation. A \$50.00 "No Show" fee for regular appointments and a \$100.00 "No Show" fee for surgery reservations will be applied if a missed appointment occurs. As a courtesy, we attempt to call and remind you of your appointment. Patients will receive a series of three text message reminders or an automated voice recording regarding upcoming appointments. The patient's responsible for updating the clinic on any phone number changes. Unfortunately, when one patient cancels without giving enough notice, that prevents another patient from being seen or treated.

Please text or call us at (708) 873-0088 by 2:00 p.m. on the day before your scheduled appointment to notify us of any changes or cancellations. Please text or call our office by 2:00 p.m. on Friday to cancel a Monday appointment.



Ticho Eye Associates Financial Agreement Acknowledgment

By signing below and/or being seen at our practice you acknowledge that you have reviewed, understand and comply with all the policies and procedures written.

Client Signature (Client's Parent/Guardian if under 18)

Date

***Copies of our Financial Agreement and CCOF Policy are available on our website at
www.tichoeye.com