OPHTHALMOLOGY ASSOCIATES OF SAN ANTONIO

210.223.5561
OphthalmologySA.com

PATIENT FINANCIAL POLICY

Thank you for choosing Ophthalmology Associates of San Antonio (OASA) for your eye care. We are dedicated to a successful physician-patient relationship with you. Your clear understanding of our Patient Financial Policy is vital to this relationship. Please ask if you have any questions about our fees, our policies, and your payment responsibilities. You are required to notify our office of any changes in your address, telephone number, email, name, and insurance information.

Please ***read and initial*** each section below indicating your acceptance of them and sign at the end. A copy of this Patient Financial Policy will be provided to you upon request.

____ **INSURANCE POLICY:** I understand that I am financially responsible and agree to pay all the fees that are not otherwise paid by or billed to my insurance or any other third-party payer. I understand that, if my insurance policy is not active or accepted, I must pay in full for all services rendered. I also understand that if my insurance is accepted, I must pay all applicable insurance copayments, coinsurance, and deductibles at the time of service. I understand that all balances are due upon receipt. Payments may be made by cash, personal check, or credit card. I understand that the charge for a returned check is $50.00.

____ **REFRACTIONS:** I understand that a refraction is a test which allows my physician to monitor changes in my vision and determine my eyeglasses prescription. It is not covered by most insurance companies, including Medicare. I understand that I will be charged $75.00 for a refraction which is due at the time of service.

____ **REFERRALS:** I understand that if my insurance company requires a referral from a primary care physician for services from OASA, it is my responsibility to obtain this referral prior to scheduling the appointment. I also understand that I will not be seen by an OASA physician without a current referral on file if one is required.

____ **NO-SHOWS & LATE CANCELLATIONS:** I understand that if I do not show for my appointment or fail to cancel or reschedule my appointment within 24 hours of my scheduled date and time, I will be charged a fee of $75.00. If I fail to show for my scheduled surgery or fail to cancel or reschedule my surgery within three (3) days of my scheduled surgery date, I will be charged a fee of $250.00.

____ **ADDITIONAL CHARGES:** I understand that I may be responsible for payment of additional charges including, but not limited to, detailed phone consultations, after-hours phone calls requiring medical decisions or prescriptions, copying and distribution of medical records, prior authorizations, and completion of non-OASA forms.

_____ **OUTSTANDING BALANCES:** I understand that if my account becomes delinquent, and I have not established payment options with OASA, my account will be turned over to a collection agency. I further understand that outstanding balances must be resolved prior to any non-emergency appointments. If you have a financial hardship, please contact our Billing Department to discuss payment options.

_____ **WORKERS' COMPENSATION CASES:** I understand that charges for services rendered because of a verified work-related injury will be billed to the workers' compensation carrier as a courtesy if I supply the necessary information to bill the carrier. If my workers' compensation claim is denied, or if I do not provide the necessary information, I will allow OASA to bill my medical insurance carrier, and I will be responsible for any non-covered charges.

If you have any questions regarding this financial policy, call OASA at (210) 223-5561.

By signing this Patient Financial Policy, I agree to these terms and conditions.

_____

Patient Name/Responsible Party (Print)

_____

Signature

_____

Date