Association for the Blind and Visually Impaired SC

Financial Policy

Association for the Blind and Visually Impaired South Carolina has a responsibility to provide quality healthcare services to patients. In the interest of maintaining a good provider-patient relationship and continuing the delivery of quality healthcare, it is our hope that you will take responsibility for your financial obligation to our practice. Following are general policies we have established for our patients, which we believe allow flexibility that some patients need.

- ***Insurance:*** As a courtesy to our patients, we will file claims on all visits, whether they are provided in our office, in an outpatient clinic or during a home visit. When we file a claim on your behalf, it is with understanding that benefits will be assigned to the Association for the Blind and Visually Impaired South Carolina. **You are responsible for payment of deductibles, co-pay, co-insurance and non-covered services. They will be collected at the time of service.** Please remember that your insurance coverage is a contract between you and the insurance company. The ultimate responsibility for understanding your insurance benefits and for payment to your provider rests with you.

- ***Referrals:*** You are required to know whether your insurance company requires a referral from your primary care physician and obtain that referral before you are scheduled to see our providers. Our office will be happy to assist you in determining the status of any one of our providers on your insurance plan: however, this is never a guarantee of coverage. You should take the time to call your insurance company to ask specifically about the provider you wish to see and your covered benefits. Referrals typically have an expiration date and a limited number of visits so you should be careful to monitor dates and visits. Our office will not see a patient that does not have a valid referral.

- ***No Insurance:*** Patients who do not have insurance are expected to pay for services rendered. We will request payment at the time of service. We understand that individual situations may make it difficult to meet these financial expectations and are happy to discuss other payment arrangements if needed.

- ***Returned Checks:*** Your account will be charged a $10 fee for each returned check, in addition, you will be asked to bring cash for the returned check and the fee.

- ***Past Due Accounts:*** Patients who have not made an effort to make payment arrangements or have not expressed an interest in meeting their financial obligation to us may be turned over to a collection agency. Patients who have allowed their account to be turned over to a collection agency will be expected to satisfy the financial obligation (old balance), and pay for any future services in advance, before being seen by our providers. **Payment plans can be arranged, and payments are made monthly.**

- ***Out of Network Services:*** Association for the Blind and Visually Impaired South Carolina cannot make any guarantees our professional services are in-network with your insurance plan. Please note that you are responsible for any charges in conjunction with services you receive at our facility whether these are considered in-network or out-of-network with your insurance company.

- ***Non-covered services:*** We believe that your visit is relevant to evaluate, monitor and protect health. However, Medicare and certain other insurance companies will only pay for services that ***they*** determine to be "reasonable and necessary", then they will deny payment for that service. Denial of payment by your insurance company does not mean that you do not need to visit the provider.

Patient Statement:

I have been informed of the Association for the Blind and Visually Impaired South Carolina's financial policy and agree to its terms. I have been advised that Medicare and other insurance companies may deny payment for my office, clinic or home visit for the reasons stated above. If Medicare or my insurance company denies payment, I agree to be personally and fully responsible for payment.

_____ _____

Patient Signature Date

_____ _____

Printed Name Date of Birth