**Ness City Eye Care, LLC**
**PO Box 503**
**Ness City, KS 67560**

**Dodge City Eye Care**
**2020 1st AVE**
**Dodge City, KS 67801**
**Office: (785Office: 620-371-6330**
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# FINANCIAL POLICY

**Payment for the patient's portion of the exam and glasses/contacts is due at the time of service.** Payment of your expected portion is due at the time of service and should be paid when you check out. Payment for all services may be made by cash, check, or credit card. If your dependent comes to the appointment alone or is driven by another person, please be sure that you provide him/her with a means of payment. Payment arrangements by credit card may be made in advance over the phone.

**Payment for services is the responsibility of the patient regardless of insurance coverage**. At the time of your exam, we estimate your co-payment or out-of-pocket expenses based on our past experience with your policy or information provided to us by your insurance company over the telephone. Insurance companies do not inform doctors' offices of actual dollar amounts in covered benefits prior to treatment. Therefore, insurance coverage cannot be determined with certainty until the claim has been filed, sometimes making an adjustment to your account necessary once insurance claims are returned. Patients are responsible for any unpaid balance on their account after insurance reimbursement. It is the patient's responsibility to present the correct card and insurance companies on the day they are seen. If the correct insurance information is NOT presented at the day of service it will be the patient's responsibility to file on their own.

**Medical evaluations and physician referrals:** If you have a medical diagnosis for which you receive an evaluation when you see the doctor (such as headaches or dry eyes) we are required by insurance to file the visit with your medical insurance, not a routine vision rider such as the Vision Service Plan. If your medical deductible has not been met, you are responsible for the balance. Patients with managed care are responsible for getting the physician referral for any medical exam.

**Divorced parents:** In the case of a child of divorced or separated parents, the parent authorizing treatment will be responsible for all charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent. The parent responsible for the account before divorce remains responsible for any fees incurred prior to the divorce.

**Monthly Statements and Past Due Accounts:** When you have a balance on your account, we will send you a billing statement. The balance is due upon receipt and past due if not paid within 30 days. After 3 consecutive months of sending, you statements if the balance has NOT been paid off then a $50 billing fee will be added to your account. Delinquent accounts will be sent to a collection agency after 90 days, and the patient will be responsible for the collection expense of 15% of the total balance owed, legal fees, and/or court costs incurred by the practice in the process of collecting the debt. In case of a suit, the venue shall be in Ford, Kansas.

**Returned Checks:** There is a fee (currently $40) for any checks returned by your bank.

**Transferring of Records:** You will need to request in writing if you want to have copies of your records sent to another doctor or organization. This authorization includes all relevant information, including payment history. If you request your records, be transferred from another doctor or organization to us, the authorization will include all relevant information, including payment history.

**Authorization to Release Medical Information**

I authorize Ness City Eye Care, LLC that is DBA as Dodge City Eye Care to release/request medical information on my behalf to/from any entity to assist in my medical care per my request. The assignment will remain until revoked in writing.

**If you have any questions, please do not hesitate to speak with your doctor.**

- Payment for all services and products is the responsibility of the patient.
- I agree to pay all copays, deductibles, co-insurances and non -covered services as determined by my insurance company.
- I understand there is a returned check fee applied to every returned check.
- I agree to pay an additional 25% of the amount owed as a collection fee for all accounts not paid in the time stated on the final monthly statement.
- I authorize the release of medical information concerning my illness and treatment by Ness City Eye Care, LLC/Dodge City Eye Care to my insurance company.
- I authorize the release of my personal medical information to any doctor whom I may be referred to.
- I understand verification of eligibility is not guarantee of payment as stated by my insurance company.
- I authorize payment of my insurance benefits to Ness City Eye Care, LLC/Dodge City Eye Care.

**Private Health Information**

My signature below acknowledges that I was provided the opportunity to receive/review a copy of Ness City/Dodge City Eye Care's Privacy Policy Notice. We will file all insurance forms if Ness City Eye Care, LLC/Dodge City Eye Care is a participating provider for your plan. We will supply you with an itemized statement which you may submit to your insurance carrier. PAYMENT IN FULL IS REQUIRED AT THE TIME OF SERVICE.

**Parent/Guardian Signature**_____ **Date**_____

**Staff Acknowledgement Initials** _____ **Date**_____

Updated January of 2025