PATIENT FINANCIAL RESPONSIBILITY STATEMENT

Thank you for choosing **Cape Fear Eye Associates** as your healthcare provider. We are committed to providing you with quality healthcare. If you have questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy to assist in understanding your financial responsibility. We ask that you read this form in its entirety. A copy will be provided to you upon request.

The medical services you seek imply a financial responsibility on your part. This responsibility obligates you to ensure payment in full for the services you receive. If someone else (parent, spouse, domestic partner, etc.) is financially responsible for your expenses or carries your insurance, please share this policy with them, as it explains our practice regarding insurance billing, co-payments, and patient billing. By signing below and/or by receiving medical services from Cape Fear Eye Associates you agree:

1. You are ultimately responsible for all payment obligations arising out of your treatment or care and guarantee payment for these services. You are responsible for **deductibles**, **co-payments**, **co-insurance amounts**, or **any other patient responsibility indicated by your insurance carrier** or **our FINANCIAL POLICIES,** which are not otherwise covered by supplemental insurance.
2. You are responsible for knowing your insurance policy. For example, you will be responsible for any charges if any of the following apply:

   i. Your health plan requires prior authorization or referral by a Primary Care Physician (PCP) before receiving services at Cape Fear Eye Associates, and you have not obtained such an authorization or referral.
   ii. You receive services in excess of such authorization or referral.
   iii. Your health plan determines that the services you received at Cape Fear Eye Associates are not medically necessary and/or not covered by your insurance plan.
   iv. Your health plan coverage has lapsed or expired at the time you receive services at Cape Fear Eye Associates.
   v. You have chosen not to use your health plan coverage.

If you are not familiar with your plan coverage, we recommend you contact your carrier or plan provider directly.

3. You will be required to follow all registration procedures, which may include updating or verifying personal information, presenting verification of current insurance and paying any co-pays or other patient responsibility amount at each visit. If you have a balance on your account, you will be responsible for payment in full, or be set up on a payment plan. Your card or other insurance verification must be on file for your insurance to be billed. If we do not have your card on file, or are unable to verify your eligibility for benefits, you will be treated as a self-pay patient. As a self-pay patient, our fee is expected to be **paid in full at the time of service**. If the insurance card or other necessary information is

furnished after the visit, as a courtesy, we may file a claim with your insurance and if paid in full by your insurance, you will be reimbursed. If you are not prepared to make your co-pay or other patient responsibility amount, your visit may be rescheduled by Cape Fear Eye Associates.

4. We may verify your insurance benefits or submit your claim to your primary and secondary insurance carrier as a courtesy to you. It will be the patient's responsibility to file claims with any tertiary or subsequent policies. You agree to facilitate payment of claims by contacting your insurance carrier when necessary. Without waiving any obligation to pay, you assign Cape Fear Eye Associates, for application onto your bill for services, all of your rights and claims for the medical benefits to which you, or your dependents are entitled, under any federal or state healthcare plan (including, but not limited to, Medicare/Medicaid), insurance policy, any managed care arrangement or other similar third-party payor arrangement that covers health care costs and for which payment may be available to cover the cost of services provided to you. You authorize Cape Fear Eye Associates and associated physicians, staff and hospitals to release patient information acquired in the course of your examination and/or treatment including, but not limited to any and all medical records, notes, test results or other documents related to your treatment (including itemization of any charges and payments on my account) that is deemed necessary to process this claim to the necessary insurance companies, third party payors, and/or other physicians or health care entities as they require to participate in your care**. It is important to notify us as soon as possible of any changes related to your insurance coverage. Failing to do so may result in unpaid claims, and you will be responsible for incorrect information given by you or your insurance carrier regarding your insurance benefits or benefit plans**.

5. If your insurance carrier does not remit a timely payment on your claim, you will be responsible for payment of the charges within the terms set forth herein. Once your insurance carrier processes your claim, we will bill you for any remaining patient responsibility deemed by your insurance carrier. If any payment is made directly to you for services billed by us, you will promptly submit the same to Cape Fear Eye Associates until your patient account is paid in full. If you make a payment that results in a surplus on your account for which you are financially responsible, including your account, a member of your family's or dependent's account, or on any account for which you are a Financial Responsibility Party, and any remaining balance will be returned to the payor.

6. You will be mailed a billing statement that contains the total cost of your service(s) or procedure(s) received during your visit(s). You may generally expect this billing statement within twenty (20) days after your insurance company has responded to a submitted claim. You must notify us of any errors or objections to the billing statement within thirty (30) days or they will be deemed accurate, and the fees and expenses shall be deemed reasonable and necessary for the services incurred. If there is a problem with your account, it is your responsibility to contact our billing department to address the problem or to discuss a workable solution.

7. Whether or not you have insurance or are self-pay, payment of any account balance is due within thirty (30) days of receipt of your billing statement. If any balance on your account is over ninety (90) days past due, your account will be placed in bad debt.

8. We accept payment by check, cash, money order, debit cards or credit cards (Visa, MasterCard or Discover) and Care Credit.

i. **Payment by Check**. If payment is made by check and it is returned or declined for any reason, your account will be charged a surcharge of $25.00, in addition to any costs assessed or charged by any depository institution. When you pay by check, you also authorize Cape Fear Eye Associates (if your check is dishonored or returned for any reason) to electronically debit your account for the amount of the check plus a processing fee of up to the state maximum legal limits (plus any applicable sales tax). **PLEASE NOTE**: The above language authorizes an electronic debit to your account for the amount of the check plus the state-allowed recovery fee. In accordance with the rules of the National Automated Clearing House Association, this authorization is to remain in effect until Cape Fear Eye Associates has received written notice of termination in such time and in such manner to afford us a reasonable opportunity to act on it. This does not, however, mean that Cape Fear Eye Associates cannot collect a returned check fee by other check methods.

ii. **Payment by Credit Card**. You may pay with a credit card or debit card, including Visa, MasterCard, and Discover ("credit card"). Your payment with a credit card may be made in person, by mail, or by calling the number provided on your billing statement. All regular credit card rules will apply. Once authorization on the submitted information is received, your credit card will be charged. If your charge is not accepted, you will be notified. You are responsible for all late charges or penalties resulting from the late receipt of any payment. Your information is used solely to process your payment. While processing your credit card payment, only the last 4 digits of your credit card are viewable by Cape Fear Eye personnel. We do not otherwise store your sensitive credit card information. **All Care Credit payments must be made in person**.

9. **Medicare**. Cape Fear Eye Associates is a participating provider with the Medicare program and accepts as payment the Medicare allowable, patient deductible and /or 20% co-insurance. Medicare or secondary carriers do not cover some procedures and supplies. Please make certain you understand which aspects of your treatment are covered before proceeding. You understand that you will be responsible for your annual deductible, the co-payment, and any non-covered services specified by Medicare. We may submit a claim to any supplemental plan as a courtesy to you, so long as your provide all necessary policy information.

10. **Medicaid**. If you are a Medicaid patient, you must present a valid eligibility card at the time of registration and prior to the time of service. Your eligibility status will be verified monthly. Without verification of coverage, you will be responsible for the full/entire balance of your account. As a courtesy to you, your account will be billed to Medicaid when we receive all necessary information. You are responsible for non-covered portions and spend-down requirements associated with your individual coverage. If at any time you are not eligible for Medicaid coverage and wish to be seen, you will be treated as a self-pay patient and must make payment at the time of service.

11. **Managed Care (HMO, PPO, etc.)**. All managed care co-payment amounts are due at the time of service. If your insurance plan requires a referral authorization from a primary care physician, you are responsible for presenting this at your initial visit. If you request an office visit without a referral authorization, your insurance plan may deem this as "out of network" or "non-covered" treatment, and you will be responsible for a larger amount or all of the charges. You acknowledge that it is your

responsibility to be aware of what services are covered and you agree to pay for any service deemed to be non-covered or not authorized by the plan.
12. **Ancillary Services**. You may receive medical services while a patient of Cape Fear Eye Associates. By signing below, you understand that some physicians may not provide services in presence, but are actively involved in the course of diagnosis and treatment. You may incur additional charges as a result of these ancillary services. You agree to pay all charges due with respect to such services after benefits paid on your behalf by any third-party are credited to your account.
13. **Additional Charges**. Patients may incur and are responsible for the payment of additional charges at the discretion of Cape Fear Eye Associates including but not limited to:

i. Charges for returned checks ($25.00).
ii. Charges for a missed appointment without 24 hours in advance notice ($75.00) no show fee and/or ($100 fee) for missed in-office procedure and/or surgery.
iii. Charges for copying and distribution of patient medical records.
iv. Charges for extensive forms preparation or completion.
v. Any costs associated with collection of patient balances, all as allowed by law.

14. **Non-payment on Account**. Should collection proceedings or other legal action become necessary to collect an overdue or delinquent account, you understand that Cape Fear Eye Associates has the right to disclose to an outside collection agency or attorney all relevant personal and account information necessary to collect payment for services rendered. You are responsible for all costs of collection including, but not limited to:

i. Late fees and charges and interest due as a result of such delinquency.
ii. All court costs and fees (but only to the extent allowed by law).
iii. A collection to be charged under separate agreement with a third- party collections agency, either as a flat fee or computed as a percentage of the total balance due up to the maximum allowed by applicable law, and to be added to the outstanding balance due and owing at the time of the referral to the third party collection agency. You acknowledge that any such interest assessed on the account will be a late fee as a transaction. If your account is referred to a collection agency, attorney, court, or the past due status is reported to a credit reporting agency, it may have an adverse effect on your credit history; and related portions of your account, including the fact that your received treatment at our offices, may become a matter of public record. Failure to comply with any of these policies may also result in a Credit Withdrawal of Care.

15. **Authorization to Contact**. You authorize Cape Fear Eye Associates personnel to communicate by mail, answering machine messages, and/or e-mail according to the information provided in your patient registration information. Cape Fear Eye Associates, or any agent or servicer of your patient account, may use any information you have provided, including contact information, e-mail addresses, cell phone numbers, and landline numbers to contact you for purposes related to your account, including debt

collection. You authorize Cape Fear Eye Associates to use this information in any manner consistent with the information provided, including mail, telephone calls, e-mails, or text messages.
16. **Financial Responsibility Party**. If this or a separate Cape Fear Eye Associates Financial Responsibility Statement is signed by another person on your account, then that co-signature remains in effect until cancelled in writing. Cancellation in writing shall become effective the date after receipt, and shall apply hereby guarantee the full and prompt payment to Cape Fear Eye Associates of all indebtedness of Patient to Cape Fear Eye Associates, whether now existing or hereafter created (the "Indebtedness"); and you further agree to pay all expenses, legal or otherwise, incurred by Cape Fear Eye Associates in collecting the indebtedness enforcing this guaranty, or in protecting its rights under this guaranty shall be a continuing, absolute and unconditional guaranty, and shall remain in force and effect until any and all said time to first exhaust its remedies against Patient, any other party, or any other rights before enforcing the obligations of Financial Responsibility Party.

ACKNOWLEDGEMENT

By signing below, each of the undersigned acknowledges that:

i. I have been provided a copy of the Cape Fear Eye Associates PATIENT FINANCIAL RESPONSIBILITY STATEMENT.
ii. I have read, understand and agree to their provisions and agree to the specified terms.
iii. I agree to pay all charges due (or to become due) to Cape Fear Eye Associates for the below Patient's care and treatment, including co-payments and deductibles, as required or provided pursuant to my insurance plan and/or the insurance plan of another, as applicable.
iv. Benefits, if any, paid by a third-party will be credited on the Patient account.
v. Regardless of my insurance status or absence of insurance coverage, I am ultimately responsible for the balance on the account for any services rendered.
vi. If I failed to make any of the payment for which I am responsible in a timely manner, I will be responsible for all costs of collecting the money owed, including court costs, collection agency fees and attorneys' fees (to the extent allowed by law).
vii. Failure to pay when due may subject me to late payment charges and can adversely affect my credit report.

I further agree that a photocopy of this Patient Responsibility Financial Statement shall be as valid as the original.

PATIENT FINANCIAL RESPONSIBILITY STATEMENT POLICY **MR# ____________**

ONCE I HAVE SIGNED THIS AGREEMENT, WHETHER BY ORIGINAL, FACSIMILE OR ELECTRONIC (".PDF") SIGNATURE, I AGREE TO ALL THE TERMS AND CONDITIONS CONTAINED HEREIN AND THE AGREEMENT SHALL BE IN FULL FORCE AND EFFECT.

______________________________________ ______________ _______________
Patient/Responsibility Party/Guardian Date Date of Birth

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Witness

______________________________________ ______________ _______________
Patient/Responsibility Party/Guardian Date Date of Birth

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Witness