FINANCIAL POLICY

We are doing everything possible to hold down the cost of medical care. You can help a great deal by reducing the number of bills we send to you. The following is a summary of our payment policy.

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance and copayments for participating insurance companies. The **STOKEN WAGNER OPHTHALMIC ASSOCIATES** accepts cash, personal checks (in-state only), VISA, MasterCard, and Discover. There is a service charge for returned checks.

Patients with an outstanding balance 60 days or more overdue must make arrangements for payment prior to scheduling appointments.

INSURANCE:

We bill participating insurance companies as a courtesy to you. You are expected to pay your copayments at the time of service. If we have not received payment from your insurance company within 45 days of the date of service, you may be expected to pay the balance in full. You are responsible to be sure all charges are paid whether by you or by your insurance carrier.

As the healthcare industry continues to change, we are requesting that **all deductibles and coinsurances are paid prior to surgery.**

If you need assistance or have questions, please contact **The Billing Coordinator between 8:00 a.m. and 3:00 p.m., Monday through Friday at 717-249-6337.**

REFUNDS:

Patient/guarantor credits in amounts less than $20.00 will be retained on account to be credited toward future balances unless a written request for refund is received. Amounts $20.00 and greater will automatically be refunded to the patient/guarantor.

MANAGED CARE:

If you are enrolled in a managed care insurance plan (i.e., HMO), you must obtain a referral from your family doctor before seeing Dr. Stoken, Dr. Wagner or Dr. West. Retroactive referrals are not guaranteed.

MISSED APPOINTMENTS/LATE CANCELLATIONS:

Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge for missed or late-canceled appointments. Excessive abuse of scheduled appointments may result in discharge from the practice.

I have read and understand the **Stoken Wagner Ophthalmic Associates** Financial Policy. I agree to assign insurance benefits to the **Stoken Wagner Ophthalmic Associates** Practice whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections.

Signature of insured or Authorized representative: _____
Date:_____Relationship to the patient:_____