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Ophthalmology Associates & LASIK Center of Mankato P.A.
20/20 Optical

1630 Adams Street
Mankato, MN 56001
Phone: 507-345-6151
Fax: 507-625-1096
www.mankatoeyedoctors.com

PATIENT FINANCIAL POLICIES

Billing/Insurance Information:

You must provide your insurance information at every visit. Payment of your required co-pay and any non-covered services are required at time of service.

We participate or contract with most major insurance carriers, including Medicare and Medicaid, but it is your responsibility to confirm benefits and coverage prior to services provided. We will submit claims to your insurance carrier, but you remain responsible for any charges incurred regardless of your insurance coverage. All unpaid balances will be billed to you as self-pay and are due and payable within 30 days of the statement date. Past due balances may be subject to outsourcing to a third-party agency for collection, interest charges (after 30 days of the statement print date), and collection fees.

Your insurance carrier can tell you whether we are contracted with them. For any insurance plans that we do not participate or contract with, you are responsible for any unpaid balance. If unable to pay in full, you must make payment arrangements with our billing staff.

It is your responsibility to:

- Know your insurance benefits and coverage.
- Know whether a referral is required.
- Know whether pre-certification for a procedure or surgery is required.
- Notify us of changes to your insurance plan or coverage.

Managed Care Medicaid and Managed Care Insurance recipients MUST bring a copy of the referral card from your primary-care physician, or your appointment may be rescheduled. If you choose to be seen without a required referral, you accept responsibility for payment prior to services provided.

Medicare:

I request that payment of authorized Medicare benefits be made on my behalf to OAM for services furnished me by OAM. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. OAM accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

Payment methods:

We accept cash, check, Visa, MasterCard, Discover, and American Express. You may pay in person, over the phone, or securely and conveniently online via the patient portal or on our website via credit card at www.mankatoeyedoctors.com under “PAY MY BILL.”

Please note: Any payment made by check that does not clear your bank account will result in a $25 return check fee, which will be added to your account and must be paid before the next visit.

Financing with Care Credit:
Care Credit can offer interest-free loans on balances of $300 or more that are paid within 18 months and interest-bearing loans on balances of $1,000 or more that are paid within 24-60 months. You may apply on our website or request details and an application from our billing staff; or they also can approve you right here in house.

Payments and payment plans:
As a convenience, you may use our secure form to pay your bill online by visiting our website at www.mankatoeyedoctors.com or request an approved payment plan by contacting our billing department. This option offers automatic monthly credit card charges until your account is settled in full. All payment plan requests must be approved by our billing supervisor/administrator.

Bad Debt/Collections:
If your account is in collections, you cannot be scheduled for an appointment unless deemed as medically necessary by Administrator or Doctors. If not deemed as medically necessary, patient must set up payment plan and have three consecutive payments made or pay in full before an appointment can be scheduled. To schedule a surgery or procedure that is not defined as medically necessary, a patient needs to pay balance in full before scheduled. Only the Administrator and Doctors can override this policy.

Pre-authorization:
Our billing staff will assist in obtaining any required pre-authorizations and benefits detailing your financial obligations prior to your procedure or surgery.

Self-pay patients:
Payment is expected at time of service. Payments may be made by cash, check, money order, or credit card.

Minimum payment and balance due requirements: If you do not have insurance and are unable to pay in full, we require a minimum payment of $100 prior to providing office services as a new patient. For subsequent visits, a minimum of $100 is required. Any balance due requires approved payment arrangements by our billing staff. Fees for additional services such as diagnostic tests, drugs, and surgery will also require approved payment arrangements.

Minor/dependent Patients:
For all services rendered to a minor/dependent patient, the parent/guardian accompanying the patient is responsible for payment. In cases of separation or divorce, when presenting insurance cards for a dependent enrolled under a subscriber other than you, please be prepared to supply their name, address, phone number, date of birth and social security number. We request that you inform the subscriber that their insurance has been used.

No Surprise Billing: Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs, or have to pay the entire bill, if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay, and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

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"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

- Emergency services If you have an emergency medical condition and get emergency services from an out-of-network provider or facility. The most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.
- Certain services at an in-network hospital or ambulatory surgical center. When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

Minnesota also provides various balance billing protections. In most instances, your plan must hold you harmless for amounts beyond your in-network cost share amount for non-emergency services provided by out-of-network providers at in-network facilities. For more information about your rights under Minnesota law, visit www.mn.gov/commerce/ consumers/your-insurance.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  -Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  -Cover emergency services by out-of-network providers.
  -Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  -Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you think you have been wrongly billed, contact the Centers for Medicare & Medicaid Services (CMS) Centers for

Medicare & Medicaid Services phone: 800-985-3059
Visit www.cms.gov/nosurprises/consum... for more information about your rights under federal law.
Visit www.mn.gov/commerce/consumers/... for more information about your rights under Minnesota law

Acknowledgment and signatures:

By signing below, I acknowledge that I have read and understand the above Financial Policy. I understand and agree that I am financially responsible for all charges for services rendered. I hereby assign all insurance benefits to which I am entitled to Ophthalmology Associates & LASIK Center. I authorize the use of this signature on all insurance claims. I authorize Ophthalmology Associates & LASIK Center to release all information necessary to secure payment of benefits. This authorization is valid for one (1) calendar year, unless revoked in writing.

_____	_____	_____
Printed name of patient	Patient's date of birth	Date

_____	_____	_____
Signature of patient/parent/guarantor	Printed name of parent/guarantor	Relationship