

THE VITREORETINAL EYE CENTER, P.C.
FRERE GREMILLION, M.D.

FINANCIAL POLICY

Welcome to The Vitreoretinal Eye Center. In order for us to be able to deliver the quality of care that you are accustomed to, we have established our financial policies. The following is a list of guidelines that are necessary in order to continue to provide high quality care and make your visit as pleasant as possible.

PLEASE READ ALL INFORMATION AND ACKNOWLEDGE BY SIGNING BELOW.

1. Please bring to our attention any change in your insurance so we may make a copy of your card. It is your responsibility to provide us with your correct billing information in order for us to properly bill your insurance.
2. If you have a change of address, telephone numbers, employer, email address, or other pertinent information please notify the receptionist and we will be happy to update your information.
3. We will collect your co-payment or charge for non-covered services at the time of your visit. If you have a balance after an insurance payment from a previous service, we will also ask for that payment. **We accept cash, checks, Visa, MasterCard, and Discover.**
4. We will file your claim to your insurance. If we do not receive payment from them within 45 days, you will be billed for any unpaid balance.
5. **MEDICARE PATIENTS:** We are participating providers with Medicare and will bill Medicare for all your covered charges. If you have a supplemental insurance, we will also bill that for you. If payment is not received from your supplemental insurance within 45 days of being submitted, we will bill you for the balance due. If you do not have a supplemental insurance, your portion (20% of amount allowed by Medicare) will be collected at the time of service. Each year you will be expected to pay the allowed amount of your charges until your Medicare deductible is met.
6. **HMO-PPO PATIENTS:** Your co-payment will be collected at the time of service – no exceptions.
7. **SELF-PAY PATIENTS:** Patients with no insurance will be expected to pay at the time of service by cash, money order or credit card. If you will not be able to pay in full, you must contact our office prior to seeing the doctor to make payment arrangements.
8. **Returned checks:** There will be a \$30.00 fee for returned checks. Any returned check must be resolved before any future appointment can be arranged.

Remember, whether you do or do not have insurance, you are ultimately financially responsible for payment of your charges. If you have any questions regarding our financial policy, please contact our office at (228) 388-7000.

I have read and have a full understanding of the financial policy of The Vitreoretinal Eye Center.

Signature: _____ Date: _____