eye surgical associates

1710 S. 70th Street
Lincoln, NE 68506
(800) 742-2224 • (402) 484-9000

FINANCIAL POLICY

Patient Responsibilities

1. You are expected to provide our office with correct and accurate contact information and insurance coverage at the time of registration and notify us promptly of any changes. It is your responsibility to check with your insurance company to verify our doctor's participation. You must complete and sign the patient information form every year.

2. You are ultimately responsible for making sure your account is paid in full, regardless of the source of payment involved.

3. Co-payments and payments for non-covered services will be collected at the time of check-in. Deductible payments, if known, will be collected at the end of the office visit. If you do not have the means to pay at the time of service, your appointment will be rescheduled. For your convenience, we accept cash, personal checks, money orders, VISA, MasterCard, Discover and American Express.

4. For insurance plans that require pre-authorization or referral, it will be the patient's responsibility to obtain this approval prior to the scheduled appointment. If this does not occur, you may call your primary care physician to request the document be faxed to our clinic. If this cannot be obtained immediately, you may reschedule your appointment or pay in full for your services received that day.

5. Account balances are sent via text with a secure payment link, emailed to the address on file, and/or mailed. Payment is expected within 30 days of the statement date.
Failure to pay the balance within 60 days will result in a written notice. If payment is not received in full, or if you do not contact the Insurance and Billing Department at 402-484-9005 within 10 days of receiving this notice, your account may be referred to a collection agency.If you fail to notify us of an address change and we are unable to locate you, your account may be assigned to a collection agency.

6. Patients who are considered self-pay will be expected to pay in full for services provided at the time of their appointment. Self-pay patients will be provided a Good Faith Estimate prior to their appointment.

7. For children/minors seen in our office, the parent or legal guardian will be the responsible party for billing purposes. In the case of divorce or transfer of custody, the adult who brings the child for the appointment will be responsible for payment, regardless of what may be stated in the divorce decree.

8. Our office will not get involved in matters delaying payment of the account due to legal separations, divorces, or third party litigations.

FINANCIAL POLICY
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Practice Responsibilities

1. All claims for your service will be accurately coded and submitted on your behalf within 2 business days of your appointment.

2. Appropriate and reasonable action will be taken on our part to ensure the claim is processed. Follow-up will continue on the status of the claim until it is properly resolved.

3. If an overpayment occurs on an account, the appropriate party(ies) will be refunded within 30 business days.

4. All inquiries you make regarding your account will be answered honestly. If your question requires information not readily available, our billing office will obtain the necessary data and resolve the issue as soon as possible.

5. Our physicians are participating providers for Medicare and most major insurance plans. Please call your insurance company to verify our participation with your insurance plan prior to your appointment.

6. If you have questions regarding your account or this financial policy, please contact our Billing Office at (402) 484-9005.