THE Oculoplastics CENTER

Timothy F. McDevitt, MD • Adam R. Sweeney, MD
Queen's POB I, 1380 Lusitana Street, Suite 708 • Honolulu, HI 96813
Phone: (808) 599-4755 • F**ax**: (808) 599-5397
eyelids@oculoplasticscenter.com • www.oculoplasticscenter.com

FINANCIAL POLICY

Thank you for the opportunity to serve you. We are committed to providing you with the very best care possible. The following is a statement of our financial policy that outlines patient and office financial responsibilities.

PATIENT PAYMENTS

We accept cash, checks, Visa, and MasterCard for all payments that are due on your account. Copayments are due at the time of service for all office visits. For surgery or in-office procedures that are scheduled at a later time, estimated copayments are due in full two weeks prior to the scheduled surgery or procedure date. We will provide an invoice for your review. Once your insurance company or companies have processed the claim for your office visits, you will receive a statement from our office for any applicable remaining deductibles, copayments, and the Hawaii general excise tax.

INSURANCE

Our office will file claims with your insurance company. To ensure that we have the most accurate insurance information on file, please advise our office of any changes to your insurance coverage as soon as possible. For proper billing, if you have more than one insurance policy, please provide our office with all of your insurance cards upon registration.

SELF-PAY PATIENTS

Full payment is due at the time of service. For surgery or in-office procedures that are scheduled at a later time, payment is due in full two weeks prior to the scheduled surgery or procedure date. We will provide an invoice for your review.

STATEMENTS

Regardless of any claim pending, if there is an open balance on your account, a statement may be sent to you. Any balances remaining after your insurance has made payment are due upon receipt. Please contact our office for any questions you have regarding your statement.

COLLECTIONS AND NSF CHECKS

Delinquent accounts may be forwarded to our collection agency. A collection fee of $50 may be added to the unpaid balance to recover our costs for collection. In the event litigation is necessary, you may be liable for court costs and attorney fees as well. Our bank charges us whenever a patient presents a check that does not have funds available. As a result, we may pass along the fee of $35 to your account.

SCHEDULING SURGERY

Surgery scheduling requires careful planning and coordination between our office, the surgery center, and their operating room staff, as well as the anesthesiologist. Estimated copayments are due in full two weeks prior to your scheduled surgery date. We will provide an invoice for your review. *You may receive a separate bill from the anesthesiologist or Queen's Same Day Surgery center for your surgery. Our office does not generate these, and any questions regarding these statements should be directed to the phone number on their bill.*

REFUNDS

All refunds will be processed in a timely matter after the overpayment is discovered on an account, or at the time the refund is requested. When cash or check was used to make payment, a refund will be issued in the form of a check. When a credit card was used to make payment, a refund will be issued back to *the same* card that was charged, if possible. When issuing the refund back to the same credit card is not possible, a refund will be made by check.

MEDICAL RECORDS

Your medical records are held with the strictest of confidence. If you request a copy of your records to be sent to another physician or to yourself, a written authorization is required. Only the requested records will be forwarded. When bringing in another physician's records to our office, you may want to consider keeping a copy for yourself.

FORM COMPLETION

Forms you need our office to complete may be subject to a fee, depending on complexity.

I hereby give my consent for The Oculoplastics Center to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations. With this consent, The Oculoplastics Center and staff may call my home or alternative locations (as listed on my registration form) and leave a message on voicemail or in person in reference to any items that assist the office in carrying out treatment, payment, and healthcare operations, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory and/or pertinent results. The Oculoplastics Center may mail to my home or other alternative locations (as listed on my registration form) any items that assist the office in carrying out treatment, payment, and healthcare operations, such as surgery packets and patient statements. By signing below, I acknowledge that I have read and understand the information presented above and wish to receive treatment and services from The Oculoplastics Center. I agree to be fully responsible for any and all charges for services rendered.

We welcome the opportunity to answer any questions that you may have in regards to our financial policies. It is our goal to ensure that patients have the best possible care during their visits to our office.

PRINT NAME_____ DATE OF BIRTH _____

PATIENT SIGNATURE (OR PARENT/GUARDIAN) _____

DATE_____

I have provided the patient with this document and answered any questions that he/she had in regard to what is stated above. _____
Employee Initials/Date