**Our Financial Policy**

**We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy or your responsibility.**

* **All Patients must complete our “Patient Information Form” before seeing the doctor.**
* **Full payment is due at time of service (unless we have contracted with your insurance carrier**
* **Adult Patients.**

 **Adult patients are responsible for full payment at time of service (see above)**

* **Minors Accompanied by an Adult\_**

 **The adult accompanying a minor and his/her parents (or guardian) are responsible for full payment.**

* **Unaccompanied Minor\_**

**The Parents (or guardians) are responsible for full payment.**

* **Non-Emergency Treatment will be denied if:**

**A minor under eighteen is unaccompanied by an adult (unless the doctor feels there is good reason).**

**A patient with Medicaid coverage does not have a valid MASS HEALTH insurance card.**

**A”referral” is not obtainable when required by the patient’s insurance.**

**A patient has been delinquent on back payments and/or the account has been sent to our “Collection”agent.**

**A patient has missed more than three previous appointments and had been advised of being denied another appointment.**

**Acknowledgement.**

 **I have read and understand the conditions for payment to Merrimack Eye Clinic /Dr. J Capino.**

**I Understand that my insurance carrier may require a referral from my Primary Care Physician as authorization for treatment. It is my responsibility to obtain this referral. If a claim is denied by my insurance carrier for failure to obtain a referral. I will be held responsible for full balance of the claim.**

**I request that payment of authorized benefits be made to Merrimack Eye Clinic or Dr. J. Capino for services provided to me by Merrimack Eye Clinic or Dr J. Capino. I authorize the release of any medical or other information about me to process this claim and/or all outstanding claims for services provided by Merrimack Eye Clinic/Dr J Capino.**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**