Ticho Eye Associates Financial Agreement

TICHO EYE
ASSOCIATES

Thank you for choosing Ticho Eye Associates to serve your eye care needs. Please read our Financial Agreement completely, if you have any questions please ask one of our associates for assistance or call our billing team at 708.873.0088.

You will be asked to show the receptionist your current insurance cards each visit. This allows us to verify the information and assist you in collecting the benefits from your insurance company to which you are entitled.

Routine vs. Medical Exam

A routine vision exam is a screening exam which is performed as a healthy visit. It is most frequently requested by patients to determine the need for corrective lenses. ***Not all insurances cover screening exams or offer of vision benefit.*** It is your responsibility to know if you have this benefit in how often it may be available. You will be responsible for payment if your vision exam is not covered. A medical exam is billed to your medical insurance with the symptom or condition which was present on the day of the visit.

Refraction

This is a test to determine if you need a prescription for eyeglasses. ***Unfortunately, most insurance companies do not cover this test.*** The fee for this test is $40.00 and is due at the time of service.

Insurance Claims

Please bring your insurance cards to every visit in order to accurately bill your insurance company. We require that you provide accurate and current insurance information including primary and secondary insurance. Failure to provide complete insurance information will result in patient responsibility for the entire bill. Although we may estimate what your insurance company possibly will pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. ***It is your responsibility to check with your insurance company to be sure we participate with your plan.*** If we do not participate with your plan, you will be responsible for full payment.

Vision Plans - EyeMed Only

We only accept EyeMed vision plan. Please check with your plan to see if we are members, there are some EyeMed plans that we are not in network with. If we are not in network, services are payable at the time of service.

Co-Payments

Patients are expected to pay ***AT THE TIME OF SERVICE*** all amounts known not to be covered by the insurance company. These amounts include copayments, coinsurance, and/ or deductibles. Payment may be made by cash, check, and/or credit card. **A fee of $10.00** will be added if copay is not paid at the time of service.

Patients without Insurance Coverage

Self-pay accounts are for patients without insurance coverage, patients covered by insurance plans in which the office does not participate, or patients without any insurance card on file with us. It is always the patient's responsibility to know if our office's participating with their plan. If you come for an office visit and we do not participate with your insurance company, we assume you decided to see us as an out of network provider.

Ticho Eye Associates offers discounted self-pay fees to patients who are not covered under any insurance plan. The discount is offered as a courtesy because we do not have to send statements or track payment since a payment in full is expected ***AT THE TIME OF SERVICE***. The discount applies only to physician services and does not apply to any products we sell, including but not limited to eyeglasses and contact lenses.

If you have extenuating circumstances, please ask to speak with a billing team member to discuss a mutually agreeable payment plan.

Payment Plan

Extended payment arrangements for established patients may be available for larger balances. Please ask to speak with a billing coordinator to discuss a mutually agreeable payment plan. If you pay cash, please be sure to ask for a receipt so you will have a record of your payment.

CARE CREDIT *is* a financing option that is available for patient balances over $200.

****We do not accept attorney letters or contingency payments*.**

Workers' Compensation

In the case of a worker's compensation, you must obtain the **claim number, phone number, contact person, name and address of the insurance carrier** prior to your visit. If this information is not provided you will be asked to either reschedule your appointment or pay for your visit info at the time of service.

Return checks

The charge for return check is $25 payable only by cash or credit card. This will be applied to your account in addition to the insufficient funds amount period you may be placed on a cash only basis following any return check.

Minors

The parent(s)or guardian(s) who accompanies the minor is responsible for full payment and will receive the billing statements. If someone other the legal guardian is accompanying the minor patient, a permission form or a letter in writing is required for the accompanying adult to be present.

Outstanding Balances

If your account becomes delinquent and you have not established or met payment options with our billing department, your account will be turned over to a collection agency. Outstanding balances must be resolved prior to any non-emergency appointments. If you have a financial hardship, or if you are unable to pay your bill in its entirety please contact our billing department to discuss payment options. Our staff is always available to listen and help.

This Financial Policy helps the office provide quality care to our valued patients. If you have any questions or need clarification of any of the about policies come up please feel free to contact us at 708.873.0088.

Medical Records

To obtain your medical records, a completed medical record request form is required. Patients, attorneys and insurance companies requesting copies of medical records will be charged in accordance with Illinois State Law. By law, we have 30 days to complete your request, however, we strive to complete your request as quickly as possible.

$28.44 Handling Fee – Initial fee
$ 1.07 per page 1-20
$ .71 per page 21-60
$ .36 per page 61-End

- Actual mailing costs (not including handling fees).
- $10.00 rush fee if records are to be provided within two business days.
- $20.00 certifying fee (if appropriate)

Additionally, if records are requested to be faxed to another physician's office, the fax number to the physician's office will be required. As a courtesy this is offered at no charge.

No Show Fee

We kindly ask for a 24-hour notice of cancellation. A $50.00 "No Show" fee will be applied if a missed appointment occurs. As a courtesy, we attempt to call and remind you of your appointment.
Patients will receive a series of three text message reminders or an automated voice recording regarding upcoming appointment. It is the patient's responsibility to update the clinic of any phone number changes.