WILLISTON BASIN EYECARE ASSOCIATES, PC
Billing and Financial Policies

Insurance Authorization and Assignment: I request that payment of authorized private insurance company benefits, Medicare and Medicaid services or other applicable benefits be paid on my behalf to Williston Basin Eyecare Associates for any furnished services. I authorize Williston Basin Eyecare Associates to release any medical or other information about me to any private insurance company, Medicare and Medicaid or other company and its agents which might provide coverage to me.

Appointment No Show: I understand failure to arrive for any appointments or failure to give 24-hour notice of cancellation, will result in a No-Show fee of $25. I understand a reoccurrence of no- shows for my appointments may also result in being discharged from services at the facility.

All Services are the Responsibility of the Patient: Williston Basin Eyecare Associates will gladly bill your primary and secondary insurance as a courtesy (when applicable). I understand that insurance benefits must be determined prior to my exam. If I become aware of insurance coverage after services have been rendered, I agree to personally submit the claim to my insurance company for reimbursement. I understand that when my insurance company requires a referral, and I do not furnish the correct referral at the time of service, I will be responsible for payment if my insurance company refuses my claim. I also understand and acknowledge that I am financially responsible for non-covered services, no show fees, copay's, deductibles, co-insurance and any unpaid insurance balances over 45 days past due.

Collections: Williston Basin Eyecare Associates will mail three (3) statements and a delinquent account letter in an attempt to collect any balances due, prior to sending to collections. It is my responsibility to make sure that Williston Basin Eyecare Associates has my correct mailing address and if my mail is returned by the post office, I understand that my account will go to collections upon receipt of returned mail.

Insurance Eligibility and Verification: Williston Basin Eyecare Associates will gladly verify eligibility of your insurance as a courtesy. I understand that it is my responsibility to know if I or my dependents are eligible and what benefits are covered within my vision/health plan. I also understand that benefits outlined by insurance company are not a guarantee of said amounts until claim is submitted and processed.

Payments, Co-pays and Deductibles are Due at Time of Service: I understand that not all services and materials may be covered by my insurance or may exceed benefits or coverage. I agree to pay all payments, co-pays and deductibles at the time of service for all services and materials. If my insurance company takes back any payments made to Williston Basin Eyecare Associates I understand that I will then be responsible for that unpaid balance.

Returned Checks: There is a $40.00 fee for any check returned by the bank. This fee will be added to the unpaid balance and must be paid by cash or credit card.