Financial Policy
Effective: January 1, 2019

The Vision Institute of Michigan and Vision Institute of Michigan Surgery Center (collectively known as VIM) have been providing eye care services in our community for 44 years. VIM has a responsibility to operate in a financially prudent manner to allow us to continue our mission; this includes collecting amounts due prior to rendering services to allow us to continue to serve our community. Amounts due include personal obligation such as copays, deductibles and past due balances.

VIM's values demand that our patients come first, we must be financially responsible to continue to serve. For those patients experiencing financial hardships we offer financial assistance options when necessary and appropriate. These options include payment plans and Care Credit plans.

- I understand that it is my responsibility to know my insurance benefits and plan coverage. My insurance may or may not cover the services provided at VIM. To obtain the most accurate information, please check with your insurance carrier to discuss the benefits provided by your plans prior to your visit to fully understand your anticipated out of pocket costs.
- I understand that payment of co-payments, deductibles and non-covered services are to be paid at or before the time of service. VIM accepts cash, checks, American Express, MasterCard, Visa, Discover, Care Credit and Debit Cards.
- I understand that I may be contacted by the telephone regarding my outstanding balance with VIM. I acknowledge and agree that VIM, its affiliates and agents may use an automated telephone dialing system, pre-recorded or artificial voice calls, messages, and/or texting, to contact the wireless number (s) and/or residential lines you provided to Vim for appointment and payment purposes. I further agree to allow VIM and anyone who collects on its behalf to contact me about my account status, including past due or current charges, using pre-recorded or artificial voice calls messages, and/or texting, delivered by an automatic telephone dialing system to any wireless phone number (s) and/or residential lines I provide or that is provided to VIM on my behalf by my authorized representative.
- I understand that if I do not have my insurance card, referral, and/or co-payment, that my appointment may be rescheduled until such time that I can provide the required documents or payments.
- I understand that VIM will collect, prior to any surgery or procedure, deductibles and coinsurance up to an amount equal to payment in full for the planned surgical procedure. Payment in full and expected coinsurance payment responsibility are determined by the anticipated surgical billing code(s), details of your insurance policy, and agreement between your insurance company and VIM. If the full deductible is not applied to your claim by your insurance company, VIM will apply the overpayment to other outstanding dates of service with a patient financial responsibility before a refund is issued.
- I understand if my account has a patient responsibility amount that is not paid in full within 90 days then my account will be placed with an outside collection agency. I understand that I will pay any additional fees to cover collection costs. No additional appointments will be made for delinquent accounts until they are brought current unless the appointment is of an urgent nature.
- I understand that if I have made a payment plan agreement and I do not follow the terms of the agreement then my account will be placed with a collection agency. I understand that I will pay any additional fees to cover collection costs.
- I understand that a $35 service fee will be added for any checks returned for any reason and I will be responsible for payment of this fee and the amount of the returned check. Non-sufficient fund checks must be redeemed with certified funds (cashier's check, money order or cash).
- I understand that there may be fees associated with medical records requests and completion of forms by a physician. I understand that I may be responsible for these fees.

Statement of Financial Responsibility: I acknowledge I am responsible for all charges for services provided, including any amount not paid by my healthcare plan(s). This also applies if I am covered by Medicare, a health maintenance organization (HMO), or any other payor. VIM may participate in certain government programs and does comply with applicable billing terms and restrictions. I agree that VIM may require financial information to determine eligibility for financial assistance and/or payment plan options. Information on financial assistance is available by contacting our Billing Department at 586-323-5025. I have read and I understand the above Financial Policy and I agree to abide by its terms.

Printed Patient Name: _____

Patient or Guarantor Signature: _____ **Date**: _____

Printed Guarantor Name: _____ **Relationship**: _____