Dr. Christina Fox
236 S. Sandusky Ave.
Bucyrus, Oh 44820

Financial Policy

Thank You for choosing us as your eye care provider!
The following is a statement of our financial policy. Please read carefully prior to any services performed.

Non-Insured Patients:

Cash paying patients will be responsible for all services rendered. When purchasing materials such as contact lenses, glasses, etc; We require a 50% deposit with the balance due upon delivery of those materials. All materials and solutions, which can be ordered and delivered on the same day, must be paid in full when ordered.

Insured Patients:

Your insurance policy is a contract between you and your insurance company. We will submit charges to your insurance company if we Are a participating provider, and you have given us all of the required information. We must have the most current copy of your insurance information or card. You must notify us immediately of any change in your insurance coverage. Our receptionist will gather most of this information, when she schedules or verifies your appointment via telephone. Please be aware that some and perhaps all of the services provided may be considered "non covered services" according to your policy or your eligibility. You will still be responsible for payment of these services.

If we are a non participating provider with your insurance company, you will be responsible for charges at the time of service. We will assist in completion of any forms you have available the day of the appointment.

Authorization and Referrals:

At the time of your office visit you are responsible for all professional fees and materials if referral or authorization is not received. Please check with our receptionist for the current list of insurance companies with which we participate. At the time of service we will collect the co-payment indicated by your insurance. You will be responsible for any deductibles, co-insurance or non-covered services.

Minor Patient (under 18 Years)

The parent/guardian/adult accompanying a minor child is responsible for full payment. If both parents have insurance the parent with the first birthday in the year is most often the primary insurance. Please check with your insurance carrier/policy to determine which company is the primary before the appointment. In divorce cases, the parent who brings the child in for services is the responsible party.

Payment Options

We accept these payment methods (Visa, MasterCard), cash, and checks.
PLEASE NOTE:
There will be a $25 charge for any NSF (Insufficient Funds) checks returned to our office-plus any magistrate fees if further collection proceedings are deemed necessary.

Collection Balances

If you have had a previous collection balance or are presently in collection, it will be required that you pay your previous balance prior to being seen again or ordering any new materials. A late fee of $2 per month will be added to your bill if not paid by the next monthly billing statement.

I have read the above financial policy. I understand and agree to this financial policy.

_____INITIAL

Insurance Signature on File

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct.
I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits and I request that payment of these benefits be made either to me or on my behalf to Dr. Christina Fox for any services or materials furnished. I authorize any holder of medical information about me to release in the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits payable to related services.
If I have other health coverage (an indicated in Item 9 of HCFA-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

_____ INITIAL

Acknowledgement of Receipt

I acknowledge that I have received a copy of Dr. Christina Fox's Notice of Privacy Practices.

_____INITIAL

HIPAA Authorization

Please list the family members or other persons, if any, whom may be informed about your general medical condition and your diagnosis (including treatment, payment, and healthcare operations.

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_____INITIAL

Medical Waiver

It is my understanding that Dr. Christina Fox wants to do medical testing and/or medical procedures due to my diagnosis. I also understands that tests will be billed to my medical insurance. I understand that the full amount submitted to my medical insurance may not be covered, applied against my deductible or coinsurance. If that were to be the case I will be responsible for the balance. Our billing provider will issue a statement.

_____ _____
Signature Date

Signature for Above Policies

I HAVE READ AND UNDERSTAND ALL AREAS WHERE I INITIALED ABOVE. MY SIGNATURE BELOW INDICATES THAT I UNDERSTAND AND AGREE TO THESE POLICIES.

_____ _____
Signature of patient if adult Date

_____ _____
Signature of parent or guardian Date
(If patient is under age of 18)