



FINANCIAL POLICY AND BILLING DISCLOSURE

Thank you for choosing Colorado Ophthalmology Associates for your Vision Care. We ask that you carefully read and sign this *Policy and Disclosure* prior to your treatment.

- Upon arrival, please sign in at the front desk and present your current health insurance card and driver's license or another acceptable form of ID. You may be asked to present both of these items at each visit.
- If you do not have health insurance, choose to bill your own insurance, or if our physicians do not participate in your health insurance plan, payment is due at the time of service.
- You are responsible to make complete insurance information available for accurate filing of claims. Complete information includes current benefit cards (primary and secondary), proper identification, and referrals from other providers if applicable. If insurance information that you provide is incorrect, you will be responsible for payment and to submit the charges to the correct plan.
- You are responsible for checking with your plan regarding provider network status and any co-payment, deductible or co-insurance that you may owe. Co-payments and co-insurance are a contractual obligation with your insurance company, which you are required to pay and we may collect prior to service.
- We do not participate in all plans. Our office and providers are "in network" only with some health plans. We will attempt to verify coverage as a courtesy. Insurance, however, is an agreement between you and your insurer and you are ultimately responsible for confirming information about coverage. Accordingly, to the extent you receive any "out of network" services from our office you do so **intentionally**.
- Not all services provided by our office are covered by every health insurance plan. Any service determined NOT to be covered by your plan will be your responsibility.
- You are responsible for any unpaid balance regardless of your insurance company's arbitrary determination of usual and customary rates.
- For scheduled appointments, prior balances must be paid prior to the visit.
- We require 48-hour notice for canceling any appointments. A cancellation fee may apply.
- A \$25 fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.
- A \$35 fee is required for completing patient forms regarding disability insurance, life insurance and FMLA.
- If you have a surgical procedure, in addition to a bill from your providers in our practice, you may also receive bills from other providers (for example, anesthesiologists) and from the hospital or surgical center.
- You are responsible to keep your account current as to charges for which you are responsible. In the event that you fail to pay charges, Colorado Ophthalmology Associates, P.C. is entitled to take whatever action is necessary to collect such charges and you will be responsible for reasonable attorney fees and costs incurred as a result of such collection.

BALANCE BILLING RIGHTS

You are responsible for the cost of all uncovered services and cost-sharing amounts required by your health plan for any covered services (copayments, deductibles, and/or coinsurance).

When an out-of-network health care provider bills the difference between what an insurer decides is the eligible charge for a covered service and what the provider bills as the total charge, it is referred to as "balance" billing. Colorado law protects against balance billing only when a person receives **emergency** services in Colorado, or **unintentionally** receives covered services from an out-of-network provider at an in-network Colorado facility. This law does NOT apply to ALL Colorado health plans. It only applies if you have a "CO-DOI" on your health insurance ID card. In such cases:

EMERGENCY SERVICES: If you receive covered emergency services in Colorado, in most circumstances, the most you can be billed is your plan's in-network cost-sharing amounts. You cannot be balance-billed other amounts. This includes both the emergency facility and providers that see you for emergency care. Not every service provided in an emergency department is an emergency service.

NONEMERGENCY SERVICES: At an in-network facility, you have the right to request that in-network providers perform all covered medical services and if an in-network provider is not available the most you can be billed for covered services is your in-network cost-sharing amount (copayments, deductibles, and/or coinsurance) and you cannot be balance billed for additional costs. Colorado Ophthalmology Associates and its providers may or **may not** be "in network" with your insurance plan and you are responsible for verifying network status with your health plan. By proceeding with out-of-network services, you are responsible for all charges for services.

ADDITIONAL PROTECTIONS

- Your insurer will pay out-of-network providers and facilities directly for covered services.
- Your insurer must count any amount you pay for emergency services or certain out-of-network services (described above) toward your in-network deductible and out-of-pocket limit.
- Your provider, facility, hospital, or agency must refund any overpayment within 60 days of being notified.
- No one, including a provider, hospital, or insurer can ask you to limit or give up these rights.

If you receive services from an out-of-network provider, facility or agency in any other situation, you may be balance billed and be responsible for the entire bill. If you intentionally receive nonemergency services from an out-of-network provider or facility, you may also be balance billed and are responsible for the entire bill.

It is your responsibility to know your health care benefits and coverage limitations.

We will be happy to address any questions you may have. If you want to file a complaint, or have further questions, you can submit a complaint or questions to:

Info@ColoradoOphthalmology.com
Colorado Ophthalmology Associates
303-320-1777 ext. 4 (Billing Office)
303-320-1777 (Denver) / 303-989-2023 (Lakewood)

An online complaint may also be made by visiting: <https://doi.colorado.gov/for-consumers/file-a-complaint> or [https://www.colorado.gov/pacific/dora/DPO File Complaint](https://www.colorado.gov/pacific/dora/DPO_File_Complaint).

I have read and understand this Policy and Disclosure and accept responsibility for any payment that becomes due as outlined above. I agree to pay for all services rendered not covered by my insurance and to notify this office should there be any change to my health insurance coverage.

Patient or Person with Authority to Consent

Date