JOSEPH D. WALRATH, MD – OCULOPLASTIC SURGERY
800 MT. VERNON HWY NE
SUITE 135
ATLANTA, GA 30328

COORDINATOR: 770-804-1684 EXT.119
CALL CENTER: 866-527-3722

Financial Agreement and Policies

Financial Policy/Insurance Submissions

Payment in full is required at the time of service for all past due balances, deductible amounts that have not been met, non-insured patients and any other coverage that could not be verified at the time of service. As the patient you are required to pay the co-pay/coinsurance at the time of service. Claims are billed to the insurance carrier as a courtesy; however, you are responsible for payment of all charges incurred. Please be advised there are some clinical and surgical procedures that your insurance will not cover; therefore, by signing this document, you agree to be held financially responsible for services rendered on or before the time of surgical or clinical service. All balances not paid by the insurance carrier within 90 days of the date of service will be your responsibility. We will be happy to refund you for any payments made by you after your insurance company has paid in full for covered services.

Dr. Walrath/Woolfson Eye Institute will make all effort possible to obtain insurance verification and coverage benefits prior to appointments but it is also the patient's obligation and responsibility to ensure that Dr. Walrath/Woolfson Eye Institute is a participating provider under the patient's health plan and the patient is knowledgeable in regards to their health coverage and benefit policy.

_____Initial – I have read and agree to the above statements.

Insurance Changes

If you have any changes to your insurance information, please notify our office immediately. Dr. Walrath/Woolfson Eye Institute will not be responsible for timely filing if we do not receive the correct insurance information prior to or at the time of the visit. I understand it is mandatory to notify my provider of any other insurance responsible for paying for treatment.

_____Initial – I have read and agree to the above statement.

Returned Checks

All checks returned for insufficient funds, closed accounts, or for any other reason will be subject to a $25.00 service charge. All further payments must be made either by credit card, money orders or cash.

_____Initial – I have read and agree to the above statement.

Deductibles/Coinsurance/Co-payments

Deductibles, coinsurance and co-payments will be collected at the time services are rendered. These are required by your insurance company and agreed upon by you when you accept their insurance. We also must contract with insurance companies, agreeing to collect co-payments, coinsurance and deductibles in order to participate with their plans.

_____Initial – I have read and agree to the above statement.

Collection Policy

Any balances not paid within 90 days from the date the charge is turned over to patient responsibility will be turned over to an outside collection agency. Balances are turned over to patient responsibility once insurance has processed the claim and determined patient responsibility. Balances will also be turned over to patient responsibility if insurance is unable to process claims due to missing or incomplete information not provided by policy holder to their insurance company. Any account turned over to collections will be assessed a collection fee of 30% of the total amount due.

_____Initial – I have read and agree to the above statement.

Social Security Number

Our office policy requires your social security number be provided for billing and insurance purposes. By declining to provide us with a social security number, you agree to pay for your services prior to services being rendered.

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Surgical Predetermination Process

Predetermination takes place prior to surgery and requires that a letter of medical necessity, any photographs and/or testing be sent to your insurance company for review and possible approval. This process can take four to six weeks, and if surgery is approves, there is no guarantee of payment. *Should you wish to proceed with an unapproved surgical procedure, you will be asked to sign the waiver in lieu of insurance claim filing, and we will ask for payment in full. Dr. Walrath/Woolfson Eye Institute will not refund any private pay monies collected on an unapproved surgery. You may wish to file the claim on your own and agree to accept what your insurance company PAYS YOU after the surgery has taken place.*

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External Photo Charge

In order to evaluate and treat your condition, external photos may be required. Although insurance companies require proper documentation with photos, it may not be a covered service. A photo charge of $15.00 is due at the time of initial service. This charge is in addition to your office visit, copay or deductible. If you are covered by insurance, we will file for this charge for reimbursement. If we are reimbursed by your insurance company for this charge, your account will be credited back the fee.

I understand that Dr. Walrath/Woolfson Eye Institute may use photos for the treatment of my care. I understand that the charge may not be a covered service and that I am responsible for payment at the time of service.

_____Initial – I have read and agree to the above statement

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. We would be willing to discuss reasonable payment plans. If you have any question about the above information, please do not hesitate to ask us.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan to Dr. Walrath/Woolfson Eye Institute. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges, whether or not these charges are paid by my medical insurance. I hereby authorize Dr. Walrath/Woolfson Eye Institute to release any and all information necessary to secure payment.

Signed: _____ Date: _____

Please Print Name: _____

Witnessed by staff member: _____ Date: _____