SHEPHERD EYE CENTER
F I N A N C I A L A G R E E M E N T

Dear Patient:

Thank you for choosing **Shepherd Eye Center** as your eye care provider. The following is our Financial Policy, which will help you with your concerns regarding our billing and payment procedures.

Payment for services is due at the time service is rendered. We accept cash, checks, money orders, debit cards, MasterCard, Visa, Discover and American Express. We will submit an insurance claim on your behalf. If your carrier is not contracted with our practice, we will courtesy bill them with the understanding that whatever the insurance does not pay; the balance is then your responsibility to pay within 30 days of your first billing statement. **IF YOU HAVE A CO-PAY, IT WILL BE COLLECTED AT THE TIME OF SERVICE. Please note that we do not submit co-pays to a secondary carrier. We will give you the appropriate information to do this on your own.**

You are responsible for knowing your insurance benefits. What are covered services in your plan? Does your insurance require a Primary Care Physician (PCP) referral? Does your physician participate in the plan? **If you are an HMO member, you are responsible for obtaining referrals/authorizations from your PCP and/or carrier.** Patients are responsible for deductible balances, co-insurance and non-covered amounts **at the time of service.** Any billed balances are due within 30 days of the statement date.

Please have **ALL INSURANCE CARDS and a PHOTO ID AVAILABLE FOR PHOTOCOPYING AT ALL TIMES.** Any changes of insurance, address, phone number or emergency contact information should be reported immediately.

We appreciate the opportunity to examine and care for your eyes. In the world of health insurance, Medicare and most other carriers will **NOT COVER THE REFRACTION PART OF THE EXAM.** This part determines whether your vision can be improved or not with glasses and is needed to dispense glasses or obtain approval for **ANY** surgery. **Therefore, we want you to be aware there is a $40 fee for the refraction testing due at the time services are rendered.** If you have any questions, please feel free to ask.

Remember that insurance authorizations/referrals for services do NOT guarantee payment. If your insurance does not pay in full within 60 days, we ask that you contact them as charges will then be transferred to you. We require you to pay the balance due even though your insurance carrier may eventually process your claim. A refund will then be mailed to you. Interest on past due balances will accrue at a rate of 1.5% monthly. There will be a $25.00 fee for all returned check items. Should your account become delinquent and be referred to a collection agency, you shall be financially responsible for the costs of collection and/or legal fees. Collection costs are calculated by adding to the principle the greater of $25 or an amount 35% in excess of the balance owed.

I request that payment of authorized Medicare/or any third party benefits be made to the SHEPHERD EYE CENTER on my behalf for any services rendered to me. I authorize any holder of medical information about me to release to the Center for Medicare/Medicaid Services and its agents or any third party payor any information to determine these benefits or the benefits payable for related service.

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Printed Name of Patient/Responsible Party | Signature of Patient/Responsible Party

_____ _____

Patient Date of Birth | Date