PATIENT PAYMENT OPTIONS

Thank you for choosing us as your eye health care provider. We are committed to your care being successful. We believe that everyone benefits from a clear financial agreement before treatment. To make your financial arrangements as easy as possible, we have the following methods of payment:

o **PAYMENT UPON SERVICE**. Payment in full on date of service. We accept cash, debit checks, Visa, Mastercard, Discover, American Express and Diners Club

o **INSURANCE (participating).** If you have an insurance plan that we do participate with, you will be responsible for any co-pay or percent of the charges that your insurance plan does not cover on the date of service. We will submit the claim on your behalf. If a balance remains on your account after the insurance company processes your claim, this balance will be due immediately. You authorize this office to act as your agent in helping obtain payment of insurance benefits. Any unpaid claims that are denied because the office did not have a current referral or correct coverage information remains your responsibility.

Name of Main Policy Holder if Different from Patient_____

o **MEDICARE.** I authorize this office to act as my agent in helping me obtain payment of my insurance benefits. I request that payment of authorized Insurance benefits (including Medicare), be made either to me or on my behalf to Drs. May, Hettler, and assoc. for any services or materials furnished me by this office. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits payable for related services. If I have other health insurance coverage (as indicated in Item 9 of the 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 this office to act as my agent, as above.
I have also been advised that based on Medicare B guidelines some routine services may be denied as not medically necessary. Therefore, I acknowledge and accept liability for payment of these services such as 92015 ($14.00). Standard frames are available if covered, but deluxe frames are optional and at an additional fee.

Medicare No _____ Secondary Insurance No._____

Interest: All balances that are the responsibility of the patient must be cleared immediately when payment is due. Balances remaining after this time will be subject to 1% interest per month, and up to 12% per year, until payment is received.

I certify that I am the patient or duly authorized person to release and receive insurance and medical information. In the event that my insurance should not pay for the products or services provided, I agree to be responsible for all charges. I have read the information contained in this financial form and agree to the terms listed. I also agree to pay all costs of collections and attorney fees in an amount equal to one-third of the balance due on my account. There will be a $25.00 fee assessed on all returned checks.

Print Name (Name of guardian if patient is a minor)

_____

Signature Date

_____ _____