

# Children's Eye Clinic, P.C.

## Financial Policy

Child's Name: \_\_\_\_\_

Child's Date of Birth \_\_\_\_\_

We continually strive to control healthcare costs and maintain a high level of professional care. Any successful attempt to control healthcare costs must be a combined effort involving the patient/parents, our office and the benefit plan carrier. One of the costliest aspects of doing business is carrying past due balances and sending out billing statements. **In order to eliminate the expense of sending out billing notices, all fees for certain services are due at the time of the visit.**

**The following items are to be paid for at the time of your visit:**

Routine Eye Examinations

Co-payments

Deductibles

Co-insurance amounts

**Refractions:** This is a non-covered service by most insurance companies. If your insurance company pays the refraction fee, we will refund this amount to you in a timely manner.

**Our office accepts cash, check and MasterCard, Visa or Discover credit cards.**

It is your responsibility to pay any fees to this office for services regardless of your benefit limitations.

A fee of \$25.00 will be added to your account for a returned check. There is a \$10.00 fee for charges over 90 days old unless prior arrangements have been made with our office.

In cases of separation or divorce, our office is not a party to any separation or divorce decrees. The parent bringing the child to the office is responsible for any fees due. The office will not split billing between the parents.

In case of default, your account will be turned over to a collection agency.

### Benefit Assignment Authorization

I authorize the release of information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf and I assign the benefits payable to which I am entitled to Children's Eye Clinic, P.C. 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 document.

**I certify that I have read and fully understand and accept the above financial policy.**

Signature of Parent or Guardian: \_\_\_\_\_

Please print Name of Parent or Guardian: \_\_\_\_\_

Date Completed: \_\_\_\_\_