Prairie Eye Center, Ltd.

Financial Statement

Payment for services rendered (**including insurance co-pays**) is expected at the time of service unless services are billable and covered by insurance. Payment arrangements are available for professional services they must be discussed with a billing department representative prior to receiving services. We accept Visa, Mastercard, Discover, American Express, check and cash payments for services.

Prairie Eye Center, Ltd. will file necessary claims on your behalf to your insurance carrier (providing that we are participating with the insurance plan). It is the patient's responsibility to verify coverage with your insurance company prior to receiving services by calling the member services number located on the ID card. Please remember that your insurance coverage is an agreement between you and them and we file claims as a courtesy. Any balance due whether your insurance carrier pays or denies a claim is ultimately your responsibility.

Full payment for contacts is expected at the time of dispensing. A minimum 50% of the full balance is to be paid to place an order for glasses with the remaining balance due at dispensing.

Balance billing statements are generated and mailed monthly and are payable by the due date. Should you be unable to pay by the due date, we ask that you contact the billing department to set up other arrangements for payment. In the event the balance remains unpaid, a billing department representative may contact you. Prairie Eye Center, Ltd. does not assess monthly interest on unpaid balances.

If an unpaid balance remains outstanding (usually 60 – 90 days) and we have tried to contact you (either by mail, phone, etc.) Prairie Eye Center, Ltd. reserves the right to refer the account to an outside collection agency. Should the account be referred to an outside agency, that agency may assess additional fees deemed necessary in collecting the unpaid balance and you may be held legally liable for such fees.

Prairie Eye Center, Ltd. reserves the right to refuse services or treatment at any time in the event of a failure to keep scheduled appointments and/or to follow Ophthalmologic / Optometric recommendations. **Please be advised that if an interpreter has been scheduled for your appointment and you do not show up for the appointment, you will be held liable for any fees from the interpreter billed to Prairie Eye Center, Ltd.**

There is a $20 minimum fee for the patient to receive a copy of their medical record.

There is a $25 fee charged in addition to any bank fees incurred for any checks returned for insufficient funds.

Authorization and Release

I authorize the release of any information including the diagnosis and the records of any service, treatment or examination rendered to me or my child during the period of such care to third party payers, and/or health practitioners.

I authorize and request my insurance company to pay directly, to the doctor or doctor's group, insurance benefits otherwise payable to me.

Acknowledgement of Receipt of Privacy Practices

My signature below constitutes an acknowledgement that I have read and understand the above policies as well as at any time I may (by individual request) receive a copy of the Prairie Eye Center, Ltd.'s Notice of Privacy Practices which outline how my health care information is used and shared with others.

Patient Signature (if over 18 years of age)

_____ **Dated:** _____

Guarantor signature

_____ **Dated:** _____