PRAIRIE
Eye Center, Ltd.

Patient Financial Agreement

Patient Name: _____ Account #: _____

Insurance Coverage: It is your responsibility to provide us with your insurance details, a copy of your insurance card, a photo ID, and to verify your coverage with your carrier before receiving services. Payment in full is expected at the time of service if we are unable to determine your benefits or if you have a self-pay insurance plan (either you do not have insurance or have a plan in which we do not participate). Please note that your medical insurance card does not necessarily indicate that you also have a separate vision plan.

Payment: Payment for services rendered (including insurance co-pay and co-insurance) is expected at the time of service unless the services are billable and covered by insurance. We accept payment by Visa, Mastercard, Discover, check, or cash. Payment arrangements may be available for professional services but must be discussed with a representative prior to receiving the services. Full payment for contact lenses and eyeglasses is expected at the time of ordering. There may be a fee for patients to receive a copy of their medical record. There is a $35 fee, in addition to any bank fees, for checks returned for insufficient funds. Failure to provide a 24-hour notice for an office visit may result in a $30 "No Call No Show" fee and failure to provide a 48-hour notice for a surgical procedure may result in a $45 "No Call No Show" fee.

Insurance Claims: Prairie Eye Center, Ltd. will file insurance claims on your behalf as a courtesy. Your insurance coverage is an agreement between you and your carrier, and the patient portion of a claim is determined by the carrier. If you have any questions or concerns about your coverage, you should contact your carrier directly.

Balance Billing: Balance billing statements will be mailed to you monthly and are due by the specified date. If you are unable to pay by the due date, please contact the billing department to make other arrangements. Prairie Eye Center, Ltd. does not charge interest on unpaid balances. If an unpaid balance remains outstanding (greater than 90 days) and we have attempted to contact you (by mail, phone, etc.), Prairie Eye Center, Ltd. reserves the right to refer the account to an outside collection agency. If the account is referred to an outside agency, that agency may charge additional fees to collect the unpaid balance and you may be held legally liable for such fees.

Signature and Agreement

By signing below or by electronic signature, I confirm that I have been informed of and understand the above-outline policies. I authorize Prairie Eye Center, Ltd. and/or its affiliates to act as my agent in utilizing my insurance and/or agent in utilizing my insurance and/or Medicare to obtain reimbursement for any services and materials furnished. I authorize the payment of these benefits to be made directly to Prairie Eye Center, Ltd. and/or its affiliates on my behalf. I also authorize any holder of my medical information to release any information needed to determine benefits payable for related services. If I have additional insurance, I authorize the release of my medical information to any insurer or agency I have designated and authorize my doctor to act as my agent in these matters. If my insurance does not cover any portion of my visit(s) or materials, I understand that I am responsible for payment of these services or materials. This authorization is effective for my lifetime unless revoked in writing.

Signature of Patient or Legal Representative: _____

Patient Name: _____ Representative Name: _____(please print)

Date: _____ Relationship to Patient: _____