GOODYEAR EYE SPECIALISTS
13657 W. McDowell Rd. Ste. 209
Goodyear, AZ 85395

CREDIT POLICY AND FINANCIAL AGREEMENT

- As a courtesy to you, we will file your claim with your insurance company. However, **you are the sole responsible party for all charges incurred and guarantee payment thereof**. If we are contracted with your insurance company we will accept assignment and you will be responsible for your payment portion at the time of service. **Failure to provide necessary referrals and/or authorizations or failure to provide accurate billing information will result in all charges for services becoming the sole responsibility of the patient/responsible party**. You are expected to understand your benefits coverage and responsibilities. This includes, obtaining referrals and/or authorizations, which your insurance company requires **before** care is provided. If we do not have a contractual obligation with your insurance company you are responsible for 100% of the payments at the time services are rendered. If one of our doctors is a participating physician for your primary insurance plan, payment for any deductibles co-pay amounts and non-covered services will be due at the time of service.

- It should be remembered that eye examinations, or certain other ophthalmic services, are not always covered by every insurance company. Even within the same insurance plan there may be many individual variations. It is your responsibility to know whether or not your insurance plan will cover the services that you receive in our office. It is simply not possible for the staff of this office to know how each and every insurance plan works.

- A refraction (the measurement of your eyes for a glasses prescription by either the doctor, or one of the ophthalmology technicians) is typically *not a covered benefit of your insurance plan*. In the course of your examination, when it is necessary to perform a refraction, it is with the understanding that you will be held financially responsible for this charge.

- This office accepts assignment for Medicare patients. However, each patient is responsible for payment of all non-covered costs. Examples of non-covered Medicare services would be: the refraction for glasses that is part of almost every comprehensive eye examination, the annual Medicare deductible, and any remaining balance of Medicare allowable fees not covered by the supplemental insurance plan. It is important to understand that when a participating physician accepts assignment from Medicare, it does not mean that whatever Medicare pays is to be considered payment in full. Medicare has never paid 100% of any charge. Many other insurance companies follow this same basic philosophy. The Stark II legislation, recently passed by the United States Congress, prohibits this office from extending courtesy discounts and/or professional write-offs.

- Payments on all accounts billed is expected within 30 days. If your account is sent to collections a 25% collections fee will be added.

- There is a $30 fee for appointments that are not canceled within at least one (1) day advance notice.

- By signing below, I agree to the above terms and I agree to pay any collection costs and/or reasonable attorney fees, if a delinquent balance is placed with a collection agency and/or attorney for collection, or suit.

ASSIGNMENT OF BENEFITS:

- I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan to **Goodyear Eye Specialists**. 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. I understand that I am financially responsible for all charges, whether or not these charges are paid by my medical insurance. I hereby authorize **Goodyear Eye Specialists** to release any and all information necessary to payment.

I certify that the information I have provided on this form is correct. I authorize the release of any necessary information, including medical information, for this or any related claim to the above named carrier(s), or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration. I permit a copy of this authorization to be used in place of the original. I may revoke this authorization at any time in writing.

Signed: _____ Date: _____