MIDWEST EYE CENTER

Financial Policy

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

1. Always bring your current health insurance card to your appointment.

2. At the time of check-in please notify the receptionist of any changes in your personal information such as insurance, address, and phone number.

3. Payment is required at the time of service including copay, deductibles, refraction fee, and/or any non-covered services. We accept cash, check/debit card, Visa/MC/Discover/American Express. If you are unable to pay at the time of service, payment arrangements can be made but there may be an additional $20.00 fee to cover the costs of billing.

4. Please be sure, prior to your visit that you have obtained referrals and/or authorizations required by your insurance company.

5. Please be sure to verify to the participation status of your physician with your insurance plan. We will not deny care to any patient due to uncertainty as to participation status of our physicians with your insurance plan. However, if our physician is not part of your plan your portion of the fees will most likely be higher. Ultimate responsibility for payment of all fees is yours.

6. Keep in mind that your insurance policy is basically a contract between you and your insurance company. **We will file all insurance claims for you, however, the ultimate responsibility for payment is yours.**

7. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "non-covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

8. ***As a courtesy to all scheduled patients, we ask that you give adequate notice (at least 24 hours) if you are unable to make a scheduled appointment. Those who do not give notice may be billed for the missed appointment.***

9. **I understand that I am responsible to pay for all services rendered, including attorney fees up to and including court costs in the event of default.**

10. **Return Check Fee $20.**

Printed Name of Patient _____

Patient Signature (or Legal Guardian) _____ Date _____

Staff Member _____ Date _____

Pay Online at www.tristatesight.com