FINANCIAL POLICY OF
The Eye Institute

Thank you for choosing The Eye Institute for your Ophthalmology care.
The following is the Financial Policy of the office, which you are to read and sign.

All patients must complete the patient Information form and provide your current insurance card(s) before being seen. Please understand that payment of your bill is considered your responsibility. This information is provided to avoid any misunderstandings concerning payment for professional services. If you have any questions concerning the office Financial Policy or need assistance, please feel free to call us at 918-747-3937.

INSURANCE:
As a courtesy we file your insurance claims. Your co-payments are due and payable at the time of service. Your insurance policy is a contract between you and your insurance company. It is your responsibility to remit payment for any charges not covered (coinsurance or deductible) by your insurance. You will be furnished with an itemized statement for each visit for your records. Some commercial insurance companies apply co-payments to office surgeries.

HMO/MANAGED CARE INSURANCE:
PLEASE notify our receptionist if you are covered by HMO insurance. We will need an authorization number from your Primary Care Doctor for any HMO services. If we do not have your authorization prior to your visit, your appointment will need to be rescheduled. Your co-payments are due and payable at the time of service. Most HMO's apply co-payments to office surgeries.

MEDICARE:
The Eye Institute physicians participate in the Medicare program. We will file your Medicare claims for you. Medicare pays 80% of their allowable and you will be billed for the 20% coinsurance (if you have no secondary insurance or if you're secondary insurance denies payment), deductible and any non-covered services. Examples of non-covered services are refractions and cosmetic surgery. Other services may be deemed non-covered and you will be given notice of those charges prior to services being rendered.

PATIENTS WITH NO INSURANCE COVERAGE:
Payment in full is expected at the time of service.

I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical benefits to the physician or supplier for services described in the insurance claim. I understand that some Commercial Insurance plans may not cover the total cost of treatment (due to the nature of the insurance plan or that some treatments may be considered medically unnecessary by the insurance company) and that I am responsible for my copayment, deductible and other charges not covered by my primary or secondary insurance plan(s). Medicare Patients, I understand that I am responsible for the deductible and copayment applied to my Medicare Insurance coverage. I am also responsible for any Medicare non-covered services such as cosmetic surgery and refraction.

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER, AND AMERICAN EXPRESS.

SIGNATURE OF PATIENT ______________________________ DATE: ______________
OR LEGAL GUARDIAN

SIGNATURE OF RESPONSIBLE __________________________ DATE: ______________
PARTY IF DIFFERENT FROM ABOVE