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Putnam Parkway Eyecare
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FINANCIAL POLICY

Our goal at Putnam Parkway Eyecare is to provide high quality, personal medical eye care, products, and services. Your understanding of our financial policy is an essential part of your eye care and treatment. If you have any questions regarding this policy, please feel free to discuss them with our staff.

Full payment for professional services is due at time of service for all co-pays and deductibles not covered by insurance. Acceptable forms of payment include cash, personal check, and credit cards. For your convenience, we accept Visa, MasterCard, and Discover. If eye wear or contacts are ordered, a minimum 50% deposit is required, and the balance is due upon delivery. A $30 fee will be charged for returned checks.

Your insurance contract is an agreement between you and your insurance carrier. As a courtesy, we make every effort to get benefit details and authorization prior to your appointment and will file your insurance today (up to 3 plans) on your behalf. For patients carrying health and/or vision insurance, we need the policy holder's social security number and date of birth.

We require having a copy of your medical insurance card. To be fair to our highly trained medical eye care provider, medical insurance may be billed for this visit or for additional testing. This may occur depending on the reason for the visit, referral/correspondence with another medical provider, and/or a medical prescription involved in your care.

After 90 days from the date of your eye examination, any outstanding balances will be sent to our collection agency if it is deemed that the account has been in default of payment. If we turn your account over to a collection agent, you will be responsible for any administrative fees, attorney fees, and court costs. If you have any questions about your bill, please contact our office as soon as you receive it.

I have read and understand the financial policy of this practice and I agree to be bound by its terms. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize my insurance company to pay to the doctor all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

Signature: _____

Date: _____