Pendleton
EYE CENTER
A PROFESSIONAL CORPORATION

"A Difference You Can See..."

Financial Policy

Thank you for selecting Pendleton Eye Center for your eye care needs. Medical and vision insurance plans are very complex. The purpose of this form is to help you understand your financial responsibilities, and to prevent misunderstandings. Even if you do not plan on using your medical or vision insurance at this time, we ask that you read this form carefully, initial each paragraph of our financial policy, and then sign and date the bottom of the form.
If someone assists you in completing this form, please also have them sign and date at the bottom.

_____ I acknowledge that I am financially responsible for all charges for services and merchandise that I obtain from Pendleton Eye Center.

_____I understand that Pendleton Eye Center will make its best effort to verify my eligibility, as a **courtesy**, and Pendleton Eye Center, or its agents, will bill my insurance company on my behalf **as a courtesy.**

_____I understand that is it my responsibility to determine my insurance (or employer) benefits including deductibles, limits and co-payment amounts. (Co-payments are usually indicated on the front of your insurance cards).

_____"Deductibles" and co-payments (or "co-pays") are payments I agreed to make when I signed up with my insurance plan. I understand that Pendleton Eye Center will **not** waive or discount deductibles or co-pays under any circumstances.

_____"Co-pays" are due on the day of service. Any co-pays not made **on the day of service, for any reason,** will be billed to me at **double** the rate indicated by my insurance company and may be subject to additional collection fees as outlined below.

_____ I understand that, if requested, Pendleton Eye Center will assist me in determining my insurance or employer benefits, and will provide me with an **estimate** of total charges, however, Pendleton Eye Center will not at any time make a guarantee about insurance eligibility, insurance payments, deductible levels, or co-pay levels.

Often, after your insurance company pays your bill for services, they will designate all or part of the charges as "patient responsibility". Generally this occurs a few weeks after the date of service.
I understand that charges determined to be "patient responsibility" will be billed to me, and must be paid within 30 days of receipt of the statement. Accounts not paid within the 30 day time period will be considered delinquent. Delinquent accounts will be charged a minimum of $25 as a late fee, and after 45 days of delinquency, will be referred to collections.
I understand in addition to the fees outlined above, accounts delinquent for more than 90 days will be subject to an additional collection fee of $100.00. All patients are required to bring their accounts current prior to scheduling elective surgery.

We have made every effort to bill insurance accurately. If insurance does not pay:

_____ I understand that if insurance does not pay the claim within three months, Pendleton Eye Center will bill the patient.

_____ I understand that any patient balance due is due before next visit.

Patient name	Patient signature	Date
Assistant name	Assistant signature	Date