

WELCOME TO OUR OFFICE

Our mission is to provide you with the most comprehensive, up to date care.

INSURANCE IDENTIFICATION

We will make every effort to properly identify your coverage and to submit claims on your behalf to your carrier to obtain their payment. Your assistance is needed in this process. It is very important that you present your current insurance identification at the time of each visit to our office. The patient is responsible to know his/her insurance coverage. Please contact your insurance company prior to your appointment to see if your visit will be covered. (Some insurance plans do not have Routine Vision Coverage or your Routine Coverage is through a secondary carrier) and some medical plans have special networks, or require a referral. You as the patient are financially responsible for all services rendered with or without insurance coverage (or your parent or guardian if under the age of 18).

OUT OF POCKET EXPENSES ARE REQUIRED AT THE TIME OF SERVICE

All out of pocket expenses, which are based upon the terms of your coverage are due and payable at the time the services are rendered. Co-payments, under the terms of your insurance coverage, **MUST** be made at the time of service. If you do not have health care coverage, we require payment in full at the time of your visit. We accept cash, checks, Visa, Master Card or Discover.

PAYMENT TERMS AND AGREEMENTS

I, the undersigned, in consideration for services rendered to the patient by Burcham Eyecare Center, understand and agree to the following:

1. I understand that payment for charges are due on the date of service with the exception of insurance coverage that Burcham Eyecare center is under contract to file directly.
2. I understand that my insurance coverage may not provide payment for all charges incurred in obtaining treatment from Burcham Eyecare Center. I will be responsible for any copayment, deductible or services not covered by my insurance provider. If I do not have insurance I agree to pay all charges resulting from such services.
3. I hereby authorize Burcham Eyecare Center to file with my insurance carrier and I assign payments to Aurora Eye Physicians, P.C. our practice corporate entity.
4. I understand if I give Burcham Eyecare Center the wrong or invalid insurance information, I may be charged a \$35.00 to re file the claim. I further understand that this correction of insurance must be made to meet the insurance company timely filing requirements as part of our contract or I will have the charges transferred to me for payment.
5. I understand a fee of \$25.00 will be added to my balance for a non-sufficient fund check that is returned to us by the bank.
6. I will keep my account current as to the charges for which I am responsible. In the event that I fail to pay charges, Burcham Eyecare Center will take whatever action necessary to collect such charges through their collection agency. 1.5% finance charge will be added every 30 days.

My signature below indicates that I have read and agree to the terms set above.

Signature: _____ Date: _____

