EyeCare Associates Optometric Group

FINANCIAL POLICY

Thank you for choosing us as your eyecare provider. We are committed to providing you with the finest quality service and materials available. In order to accomplish this we need you to understand your financial responsibility. The following is a statement of our Financial Policy which we require that you read and sign prior to any service.

All Patients must complete our information and insurance form before seeing the doctor.

- FULL PAYMENT IS DUE AT THE TIME OF SERVICE
- WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER, and AMERICAN EXPRESS
- A MINIMUM 50% DEPOSIT IS REQUIREDON ALL CUSTOM EYE WEAR

Regarding Insurance

Unless we are on a particular insurance panel, we do not accept assignment (payment) of insurance benefits. However, we will submit paperwork to your insurance company on your behalf, provided that the bill is paid in full. We cannot bill your insurance company unless you bring in all insurance information and/or an original claim form. Please note that your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Also, please be aware that some and perhaps all of the service provided may be non-covered and not considered reasonable and necessary under you particular insurance program.

Usual and Customary Rates

Our practice is committed to providing the finest service available. We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary fees.

Missed Appointments

Unless canceled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping your schedules appointments.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read the above Financial Policy. I understand and agree with its terms.

X____ Date: _________________________

RELEASE AND ASSIGNMENT Date: _____/_____/_____

To:____(Insurance Company)

I hereby authorize Dr. Michael C. Morris and/or Dr. Thear Bun to release to your company or its representative, any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Medical care. I also authorize and request your company to pay directly to the above named doctor the amount due in my pending claim for basic Medical and/or Major Medical treatment or services, by reason of such treatment or services rendered to:

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(Patient)

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Signature of Insured