WALKER EYE CLINIC

OFFICE POLICIES

1. Payment for all professional services is due on the date of service. This includes co-pays, past-due balances, and exam fees. For your convenience, we accept cash, checks, Visa, MasterCard, American Express, Discover, and Care Credit.

2. There are two types of insurance that will help pay for your eye care services and optical products: vision and medical. Vision plans only cover routine vision wellness exams, along with eyeglasses and contact lenses. Vision plans do not cover medical eye care (the diagnosis, management, or treatment of eye health problems). Medical Insurance must be used for medical eye care. If you have both types of insurance plans, it may be necessary for us to bill some services to one plan and some services to the other.

3. A refraction gives you a prescription for glasses. Some insurance plans (such as Medicare) do not cover a refraction. Patients are responsible for the $40 cost if the insurance plan deems the procedure as a non-covered charge.

4. It is your responsibility to provide our office with your current insurance information at the time when your appointment is made and present your card on the date when your services are rendered. If you provide incorrect or expired insurance information, you will assume full financial responsibility for all charges incurred.

5. Patients must have a $ 0.00 balance with Walker Eye Clinic to receive any copies of their personal records; this includes glasses and contact lens prescriptions.

6. Patients not using vision or medical insurance may use your prompt pay option of $109.00 for the cost of the exam. This must be paid on the date of service.

7. New patients are expected to arrive 15 minutes early to fill out paperwork before their exam. Any patient that is 15 minutes late for their appointment will have to reschedule. If you do not notify the office 24 hours in advance, there is a $25 no-show fee (or the maximum allowed by your health plan, whichever is less) for each missed appointment.

8. Any bounced personal checks received by Walker Eye Clinic are subject to a fee of $20.00, which is to be paid in addition to the original amount on the check within 90 days.

SIGNATURE ON FILE AUTHORIZATION

I certify that the information given to me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor, Andrea Walker, O.D. to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I request that payment of these benefits be made either to me or on my behalf to Walker Eye Clinic for any services and materials furnished. I authorize any holder of medical information needed to determine these benefits payable to related services. If I have any other health insurance coverage (as indicated in Item 9 of the HCFA·1500 claim form or electronically submitted claim), my signature authorizes the release of the above medical information to the insurer or agency shown and authorizes my doctor, Andrea Walker, O.D. to act as my agent, as above.

I have read and understand the above information regarding my responsibilities to Walker Eye Clinic

_____

Printed Name

_____ _____ _____

Signature of Patient
or Authorized Representative

Relationship to Patient

Date