GRIFFIN EYE CLINIC

FINANCIAL POLICY

Thank you for choosing The Griffin Eye Clinic as your specialty eyecare provider. It is our goal to provide quality medical care for our patients. Our staff will be available to discuss our fees and our policies with you. The eyecare that you have chosen to participate in, imply a financial responsibility on your part.

We ask that all responsible parties read and sign our financial policy, as well as complete the patient information forms before seeing the physician.

To accommodate the needs and requests of our patients, we have enrolled in numerous managed care insurance programs and we will file these claims and work with you for you to receive the full insurance benefits you are entitled.

REFRACTIONS (the actual test for glasses) are considered a routine vision procedure and is billed separately from the medical eye exam. This procedure is usually NOT covered by insurance.

Payments that are due from the patient will be expected at the time services are rendered. In order to serve you better, we accept cash, check, Visa, MasterCard, Discover and American Express.

Please initial the following:

_____ 1. As a medical provider, we supply only factual information to facilitate processing your claims with your insurance company. We will not become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance and "usual and customary" charge.

_____ 2. Fees for services, which include unpaid balances, deductibles and co-payments and in some cases, co-insurance, are due at the time of service. Returned checks and unpaid balances that are considered delinquent, may be subject to collection placement and collection fees.

_____ 3. If your insurance carrier does not remit payment within 60 to 90 days of visit, we will refile your visit. However, after the second filing we do not hear from your carrier and we have rechecked all the necessary information, we will turn the balance over to the patient and it becomes their responsibility to remit payment to this office for the services that was rendered.

_____ 4. I understand that if any payment is made directly to me for services billed

by the Griffin Eye Clinic, I recognize it will be my responsibility to promptly remit payment to the Griffin Eye Clinic.

_____ 5. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, after such default and upon referral to a collection agency or attorney by the Griffin Eye Clinic, I will be responsible for all costs of collecting monies owed, including collection agency fees and that a 15% interest will be added.

_____ 6. The above does not apply for those patients that are considered Workers' Compensation. However, be advised that as a compensation patient you may be held responsible for charges in the event that your claim is denied or not paid or determined not to be work related.

_____ 7. I understand that should I fail to provide Griffin Eye Clinic with the correct insurance information and the claim will be considered untimely by my insurance company, I will be responsible for those services that were rendered.

We do understand that due to circumstances beyond your control, there may be times when you are unable to meet your obligations. Through the years, we have always cooperated with our patients during their difficult financial times and we will continue to do so. In order for us to help you, you must let us know of these times and we will be glad to make arrangements that will help you as well as Griffin Eye Clinic. You received quality medical care in good faith, please respond in like manner to your responsibility of your debt.

I UNDERSTAND THE ABOVE INFORMATION AND WILL BE RESPONSIBLE FOR THE PATIENT LISTED BELOW.

Print Name of Patient_____

_____ _____

Signature of Patient or Responsible Party Date

_____

Relationship of other than the patient