The Region's Multispecialty Eye Care Provider

"Commitment to Excellence – Spirit of Service"

PATIENT FINANCIAL RESPONSIBILITY

Thank you for choosing West Georgia Eye Care Center as your eyecare provider. We are committed to providing you and your family with the best available medical care. The following sets forth the general billing policy of West Georgia Eye Care Center. Please read the information provided below and initial where indicated. Thank you!

1. _____ Your insurance policy is a contract between you, your employer (if applicable), and the insurance company. As your medical provider, we will only supply factual information to facilitate claim processing.

2. _____ I understand that it is my responsibility to know my specialist co-pay (which can be different than my Primary care co-pay) and that payment is expected at the time of service.

3. _____ Fees for services, which include unpaid balances, deductibles and co-payments and in some cases coinsurance, are due at the time of service. I understand that if I present an insufficient funds check (NSF check) for payment on my account that I will be charged a $25.00 NSF fee. I further understand that to rectify my account, I will be required to pay in cash, money order, cashier's check or credit card.

4. _____ All charges are your responsibility whether your insurance company pays or does not pay. If your insurance carrier does not remit payment within 60 days, the balance may be due in full from you. If any payment made directly to you for services billed by West Georgia Eye Care Center, you recognize an obligation to promptly remit payment to West Georgia Eye Care Center.

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 West Georgia Eye Care Center, I will be responsible for all costs of collecting monies owed, including collection agency fees.

I understand that financial problems may affect timely payments, so we encourage you to communicate any such problems to us, so that we may assist you in keeping your account in good standing.

Printed Name of Patient: _____

_____ _____

Signature of Patient or Responsible Party Date