PAYMENT POLICY

Thank you for selecting us for your eye care needs. We want to prevent any misunderstandings regarding our payment policy, therefore, we request that you read and sign this explanation of our policy.

Our office will honor **Cash, Check, Credit Card** (Visa, Master Card, Discover, AMEX) as payment for services and materials. The agreed upon charges, outlined on your invoice, are due and payable at the time services are rendered. **If glasses, contact lenses, or other materials are included in your fees, a 50% deposit is required upon ordering and the balance is due and payable when your eye care products are dispensed.** Glasses and contact lenses will not be dispensed with an unpaid account balance.

As a courtesy to you, if you have insurance, we will file a claim for you. You are legally responsible for any balance on your account. If you fail to make payment, your account will be turned over to a collection agency and you will be obligated to pay the costs of collection, court and legal fees in addition to the balance owed Brown County Eye Care Center. No interest will be charged.

AUTHORIZATION

I authorize Brown County Eye Care Center to release to my third-party payer and/or governmental agencies any information required to file or resubmit my claim. I further authorize all third-party payers, including Medicare supplements, to pay Brown County Eye Care Center directly on my behalf. I authorize all third-party payers to provide any information required to resubmit any denied or incorrectly paid claims. **I understand I am responsible for any co-payments, deductibles, or non-covered items at the time services are rendered.** This authorization remains in effect until withdrawn by me. I acknowledge that I have received or been offered a copy of Notice of Privacy Practices for HIPAA Compliance.

I authorize the following person(s) to receive medical and/or financial information about me:

Name   Relationship

_____   _____

_____   _____

_____   _____

Signature of Responsible Party   Date

_____   _____

(Last revised: 06/08/2012)   Patient's Name   Date