Scott K. Brotherson, O.D. Financial Policy

Thank you for choosing us as your vision care provider. Our staff is committed to timely, successful, and cost-efficient treatment of your vision needs. In order for us to maintain this standard of care and at the same time, keep our fees affordable, it is necessary for us to adhere to a financial policy. Please understand that payment of your bill is considered part of your treatment and your understanding of our financial policy is important to our professional relationship. The following is a statement of our Financial Policy that we require you to read and sign prior to any treatment.

PATIENT INFORMATION:

All patients, or their agents, must complete our "Patient Information" form before receiving any services. It is the patient's (and/or responsible party's) responsibility to keep this office informed of any changes in information (i.e. change of address, phone number, insurance company, etc.)

PAYMENT INFORMATION:

PAYMENT IS DUE AT THE TIME OF SERVICE. For your convenience, we accept cash, checks, VISA, MasterCard, Discover and American Express.

WE FILE INSURANCE CLAIMS AS A COURTESY TO OUR PATIENTS

If you have insurance, we will help you receive the maximum benefits. We cannot file the insurance claim without your current and accurate information. We will not become involved in disputes between you and your insurance company, other than to supply factual information as necessary. If you prefer to file the insurance claim personally, we will be happy to supply you all information necessary to do so.

REGARDING INSURANCE:

Your insurance is a contract between you and your insurance company. In most cases, we are NOT a party to that contract. Your account with this office is your responsibility whether or not your insurance company pays. If your insurance company has not paid your account in full within 60 days, your account will become a "CASH" account with the balance due and payable immediately.

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_____Regarding insurance plans where we are a participating provider, all co-pays, deductibles and overages are due at the time of service.

_____Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under some insurance policies. The payment of any non-covered services is the patient's responsibility.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the highest standard of health care for our patients. We make every effort to align our fees with what is considered to be usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of "Usual and Customary Rates".

ADULT PATIENTS

Adult patients are responsible for full payment at the time of service

(Continued on Reserve Side)

MINOR PATIENTS

The adult accompanying a minor and the parents (or guardians of the minor) is responsible for full payment of the minor patient's account at the time of service. Under no circumstances will we become involved in any domestic disputes. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit card, or payment by cash or check has been verified at the time of service.

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_____MATERIAL ORDERS

Please be advised that all frame, lens and contact lens sales are final. We do not offer refunds on materials ordered. We do, however, provide one free redo for any prescription issues when we are notified within 30 days.

UNRESOLVED ACCOUNTS

Finance charges of 1 ½% per month (18% per annum) will be assessed to any unpaid balances. Any account not resolved within 120 days will be forwarded to a collection agency. A $25.00 charge will be assessed to any collection amounts.

Any check returned to us unpaid by the banking institution will be assessed a $25.00 fee. Unfortunately, if a check has been returned to us, we will no longer be able to accept checks from you.

Thank you for understanding our financial policy. Please let us know if you have questions or concerns. Our strict adherence to this policy serves to enhance our provider/patient relationship.

I have read the Financial Policy. I understand and agree to this Financial Policy.

X_____ _____

Signature of patient or responsible party Date