INLAND EYE SPECIALISTS, A MEDICAL CORPORATION
OUR FINANCIAL POLICY

As stated in the Consumer Protection Act, **Inland Eye Specialists** would like to inform you of our policies concerning the financial responsibilities you incur as the result of the treatment we provide you and your family.

1. You will be billed for any unpaid office visits and procedures. As a part of our service, we will submit insurance claims on your behalf, once you have provided us with the necessary information. Please note that:
   - Since your insurance is normally a contract between the insurance company and you or your policyholder, we are not part of that agreement. We bill your insurance company as a courtesy. If it is determined that you are ineligible for benefits under your health plan or you receive noncovered and/or nonauthorized services, you will be responsible for payment. In some cases, we may have a specific contract with your PPO or HMO. You will be notified of those specific carriers. We will not change diagnoses to accommodate requests from your insurance carrier.
   - Our fees are usually covered up to the maximum paid by your insurance. Some insurers pay claims as a percentage, I.E., 50%, 80%, etc., of what they regard as the "Usual and Customary" charge for *their* plans. Our charges are considered appropriate for ophthalmology, optometry, medical eyewear and medical services in this area.
2. Please provide us with at least 24 hours notice if you are unable to keep your scheduled appointment to avoid a $25 no-show fee.
3. There will be a $25 charge on all returned checks.

RELEASES (to be signed by patient, or adult responsible for payment if patient is less than 18 years old)
I understand and agree that I am responsible for all noncovered, nonauthorized, and/or noneligible charges pertaining to my medical care, regardless of my insurance status. I have read the **Financial Policy** above and completed the Patient Information form. This information is true and correct to the best of my knowledge. I will notify you of any changes. I hereby authorize **Inland Eye Specialists** to release any information requested by my insurance company, admitting hospital and/or referring physicians, on my behalf or minor/dependant. I hereby assign payments received for medical services rendered to me and my family to **Inland Eye Specialists**. I hereby authorize **Inland Eye Specialists** to make complaints to the State Insurance Commissioner, the Health Care Financing Administration, or the Department of Labor on my behalf regarding my benefits claims.

Signed: _____ Date:_____

A test for eyeglasses (refraction) is often performed during a yearly eye examination. MEDICARE AND/OR YOUR MEDICAL INSURANCE WILL NOT COVER PAYMENT FOR THIS EXAMINATION. If you have a test for eyeglasses (refraction) today and you do not have a vision plan, you will be charged a reduced fee of $49.00. If you have a vision plan with whom we are contracted and you are eligible for services under that plan, we will bill that plan for this examination. If you do not want a test for eyeglasses performed, please inform the staff before you see the doctor.

Signed: _____ Date: _____