FLORIDA EYE & LASER INSTITUTE

2841 TAMIAMI TRAIL PORT CHARLOTTE FL 33952 (941) 883-2020

OUR FINANCIAL POLICY

- **Please understand that payment of your bill is considered part of your treatment.**
- **Payment is due at the time of service. Our office accepts cash, checks, MasterCard, Visa and Discover. Please Note:** Returned checks will be subject to additional fees. In the case that it becomes necessary for our office to enlist a collection service and/or legal services, you will be responsible for any collection and/or legal fees incurred up to 35% of your outstanding balance.

DO YOU HAVE INSURANCE?

- As a courtesy to you, we will help you process all your insurance claims. Please understand that we will provide an insurance estimate upon request, however it is not a guarantee that your insurance payment will be exactly as estimated. Your insurance and your plan benefits ultimately determine the amount paid.
  We will do all we can to ensure your estimate is as accurate as possible.
- All charges incurred are your responsibility regardless of your insurance coverage. We must emphasize that as your Eye Care Provider, our relationship is with you, our patient, not with your insurance company.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance companies' arbitrary determination of rates.
- **We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.**
- **We ask that you pay the deductible and co-payment, which is the estimated amount, not covered by your insurance, by cash, check or credit/debit card at the time we provide service.**
- Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment with 60 days, we will ask that you contact them to make sure payment is expected. If payment is not received or payment denied, you will be responsible for paying the full amount.
- If authorization by your insurance company is required to see you, it is your responsibility to either request the authorization from your PCP or request that our billing department generate an authorization in a timely manor prior to your visit/treatment. **If an authorization is required and not requested/ generated,**
  you will be responsible for payment in full.
- We will cooperate fully with the regulations and requests of your insurance company which may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim. We thank you for the opportunity to serve your eye care needs and welcome any questions you may have concerning your care or our financial policy.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY EYE CARE BENEFITS DIRECTLY TO FLORIDA EYE AND LASER INSTITUTE, L.L.C.

Consent: The undersigned hereby authorizes Doctor to perform any diagnostic tests deemed appropriate to make a thorough diagnosis of the patient's needs. I also authorize Doctor to proceed with any and all forms of treatment medication and surgery that may be indicated. **I understand that the responsibility for payment of services provided in this office for myself or any dependents is solely mine, due any payable at the time of service unless prior financial arrangements have been made. I further understand that a finance, rebilling, collection charge or attorney fee may be added to any overdue balance.**

PATIENT SIGNATURE (Parent of Child):_____Date_____