Tracy Millwood, OD

# Financial Policy:

I, _____ agree to the following terms:
(printed name of patient)

1. Payment is due at the time of service.
2. We will bill your insurance plan, but keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you, we will file your insurance claim if you agree to have your insurance company to pay the doctor directly. **You must be eligible for services at the time of the exam**. If your insurance company does not pay the practice within 45 days of billing, we will have to look to you for payment. You will need to provide a copy of your current insurance card at the time of each visit to make sure we have your proper billing information or payment will be expected at the time of service. Please be aware that the balance of your claim **is your responsibility** whether or not your insurance company pays your claim. All non-covered services will be your responsibility.
3. If there is any question/concern about charges, **please ask prior to your exam. All co-pays and deductibles are due in full at time of service.**

I have read and understand the practice's financial policy and I agree to be bound by its terms.

_____ _____

Signature of patient (or responsible party, if minor) Date