## FINANCIAL POLICY FOR BUTTE FAMILY EYE CENTER

Payment in full is expected at the time of service. If a patient has insurance, we will file the paperwork to obtain payment. Co-pays and deductibles are due at the time of service. ***Payment for materials is expected in full by pick up***.

Your insurance plan is an agreement between you and your insurance company. Vision insurance generally does ***not*** cover medical visits and medical insurance generally does ***not*** cover routine vision exams. You are ultimately the one responsible to make sure your account is paid. We file insurance claims as a service to you. If your insurance does not pay within 90 days then the account is payable by you.

By signing this statement, you authorize the doctor to release all information necessary to secure payment of benefits. You also request that payment of authorized benefits be made on your behalf to Dr. Michael Monson for services furnished to you by this office.

Parents are responsible for payment for their dependent children. For children with divorced parents, if requested, we will send a statement to both parents. However, the responsibility for the bill rests with the parent who initiates treatment.

Any accounts not paid will be subject to a 0.83% monthly interest charge (10%) annually. Any accounts not having payment received within 3 months will be turned over to a collection agency. In the event any unpaid balance is placed for collections with any third party collection agency, a fee of up to 50% of the unpaid balance will be added to the total amount due. This amount shall be in addition to any other costs incurred directly or indirectly to collect amounts owed under this agreement such as court costs, attorney fees, late fees, and any other fees so stated elsewhere. The authorized fee of up to 50% and the additional costs and charges listed above represent the actual costs incurred by Dr. Monson to collect amounts owed under this agreement and a corresponding decrease in expected revenue resulting from this signer's failure to pay as specified in this agreement.

Payment can be made using cash, check, money orders, or credit cards. The office accepts Visa, MasterCard, Discover Card and American Express. There is a $15 charge for any checks that are returned for non-sufficient funds.

I have read and agree to the above policy.

Signed:_____ Date:_____

## PRIVACY POLICY FOR BUTTE FAMILY EYE CENTER

Our office respects our legal obligation to keep your health information private. We have posted a NOTICE OF PRIVACY PRACTICES for you to review or you may request a copy for your records.

I acknowledge that I have read and understand this policy.

Signed:_____ Date:_____