Eye Physicians & Surgeons of Chicago, s.c.

Joseph B. Garber, M.D.
Gina M. Rogers, M.D.
Brian S. Herst, M.D.
Fred G. Crawford, M.D.

FINANCIAL POLICY

PATIENT PAYMENTS:

1. All patients, including self-pay and insurance-covered, are required to provide payment at the time of service. We accept various forms of payment, including cash, check, Visa, Mastercard, Discover, and American Express.

2. Self-pay patients are eligible for a discounted rate based on the type of service provided. Additional charges may apply if diagnostic tests are performed.

INSURANCE COVERAGE:

1. We will assist in filing insurance claims on your behalf, provided you provide all necessary insurance information. Please note, coverage does not always guarantee payment, in which then the patient is responsible for the balance.

2. Patients must ensure that their insurance is in-network to receive services. If your insurance is out of network, alternative payment arrangements must be made in advance.

3. Patients are responsible for all charges not covered by their insurance company, including co-payments, which are due at the time of service. We accept various forms of payment for co-pays.

4. In cases where immediate payment is not possible, pre-approved payment arrangements must be made in advance.

UNDERSTANDING BENEFITS:

1. Patients are responsible for understanding their insurance benefit plan, including any required referrals to see specialists.

BILLING AND COLLECTION:

1. Unpaid balances after 90 days may be referred to a collection agency, unless alternative arrangements have been agreed upon.

2. Patients with outstanding balances will be ineligible for future appointments until their bill is paid in full, with exceptions made for special circumstances.

FEES AND CHARGES:

1. A $30.00 fee will be charged for any returned checks (NSF).

2. The refraction test for glasses is generally not covered by insurance. This will be a $50.00 charge payable by the patient.

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APPOINTMENT POLICIES:

1. A 24-hour notice is required for appointment cancellations. A $50.00 fee will be charged for missed appointments, including late cancellations and "no-shows." This fee is the responsibility of the patient.

2. Patients who repeatedly miss appointments may be subject to dismissal from the practice, with prior notification and discussion of circumstances.

CREDIT CARD ON FILE AUTHORIZATION:

To streamline payment processes and enhance convenience for our patients, we offer the option to keep a credit card on file. The security and confidentiality of your information are our top priorities, and we employ industry-standard measures to ensure the protection of your sensitive data.

By providing a credit card for file storage, you authorize us to charge the card for any outstanding balances not covered by your insurance company, including co-payments, additional service charges, and fees incurred due to missed appointments. This authorization remains valid until you choose to revoke it in writing.

Rest assured that your credit card information will be stored securely and will only be accessible to authorized personnel for billing purposes. We are committed to maintaining the privacy and integrity of your financial information.

If you have any concerns or wish to update your credit card information, please contact our billing department promptly. Your cooperation in keeping accurate and current payment information on file is greatly appreciated and contributes to a smoother billing process for both parties.

I, the undersigned, hereby acknowledge that I have read and understood the contents of this consent form. By signing below, I freely consent to Eye Physicians & Surgeons of Chicago, S.C. Financial Consent.

PATIENT NAME: _____

PATIENT SIGNATURE: _____

PATIENT DATE OF BIRTH: _____

TODAY'S DATE: _____