THE WRIGHT EYE CENTER
FINANCIAL POLICY AND PATIENT AGREEMENT

The following is the financial policy of THE WRIGHT EYE CENTER, which you are required to read and sign prior to treatment:

PAYMENT IS DUE AT THE TIME OF SERVICE. Acceptable forms of payment are cash, check, Visa, Master Card and Discover. **All co-pays will be collected at the end of your visit.**

Most insurance companies do not cover routine eyecare and eye refractions. Payment for non-covered services will be collected at the end of your visit. If you have questions whether your insurance pays for routine eyecare, please ask to speak to our Patient Financial Services Office before your appointment.

INSURANCE FILING. Payment for health care services is your responsibility. As a courtesy to you, we will bill your primary insurance. However, in the event your insurance claim is rejected, THE WRIGHT EYE CENTER is not a party between you and your contracted insurance company. Accordingly, it is your personal responsibility to follow-up with your insurance carrier to determine the reason for claim denial. We will only bill your secondary insurance when your physician is a participating provider with your secondary insurance carrier.

HMO/PPO. All co-payments and deductibles are due and payable at the time service is provided. You are required to obtain a referral from your primary care physician prior to your appointment. You are responsible for verifying with your insurance carrier that the primary care physician referral has been approved.

MEDICARE. We will bill Medicare for you. We do accept Medicare assignment. All co-payments and deductibles are due and payable at the time service is provided.

MEDICAID. A current Medicaid card must be presented at the time of service, otherwise, your appointment will be rescheduled dependent upon availability of a valid card.

WAIVER OF MEDICAL NECESSITY. Many insurance companies will deny payment for testing and/or surgical procedures performed by your physician as not medically reasonable or necessary. In some cases, the insurance company may deny payment for the medical service (s) rendered. You agree to be responsible for the payment of all medical services. **Any medical service not paid for by your existing insurance coverage will require payment in full as services are provided or upon notice of insurance claim denial.**

(OVER)

QUESTIONS ABOUT YOUR ACCOUNT

We pride ourselves on the care our patients receive and the high level of satisfaction our patients experience following treatment by both the Physicians and Clinical Staff at the WRIGHT EYE CENTER. Our Business Office Staff is equally dedicated to helping you at any time. Please ask our staff about any policy or procedure that you do not understand. Questions may also be directed to the Patient Financial Services office by calling (719) 634-0515.

By signing this agreement, I authorize the release of medical information relating to my care to my insurance company. I authorize insurance payments to be made directly to THE WRIGHT EYE CENTER.

Special financial arrangements must be made prior to service with an addendum to this document.

Patient Agreement:

I have read and understand the financial policy as defined and agree to the terms as stated.

______________________________	______________________________
PRINT PATIENT NAME	**PATIENT SIGNATURE**
______________________________	______________________________
PATIENT SOCIAL SECURITY NUMBER	**DATE**

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