

NO SHOW AND CANCELLATION POLICY

Patients who do not keep their appointments or provide 24 hour notice of cancellation will be subject to a charge of \$50.00. This fee will be applied after the second missed appointment or second failure to provide 24 hour notice of cancellation within a 12 month period. This is not a billable charge to any insurance company and is the responsibility of the patient.

If a patient misses or cancels 3 times, we reserve the right to dismiss that patient from the care of MidWest EyeCenter. We will be happy to recommend an ophthalmologist/optometrist for their continued eye care.

MIDWEST EYECENTER POLICY REGARDING MINOR PATIENTS

The doctors of the MidWest EyeCenter do not see or treat patients under the age of 10 years old. We will be happy to provide you with the name and phone number of a pediatric ophthalmologist.

Any minor patient who has an appointment at the MidWest EyeCenter must be accompanied by at least one parent. If a parent is not present with the patient, the appointment will need to be rescheduled when the parent can be present.

**MIDWEST EYE CENTER
FINANCIAL POLICY**

Charges incurred for services rendered by the MidWest Eye Center are the patient's responsibility, regardless of insurance coverage. Assignment will be accepted for all insurance with which our practice participates. It is the patient's responsibility to provide this office with accurate insurance information, and to notify us of any changes in health insurance coverage. If you have questions on network status/participation with your insurance, it is your responsibility to contact the customer service number on your insurance card.

Patient responsibility: If your insurance has an office co-payment, co-insurance, or deductible that has not been satisfied, you must pay this at the time of your appointment.

Authorization: If your insurance company requires authorization to see a specialist, it is your responsibility to contact your primary care physician and request the authorization. Always check with your insurance before your appointment date and make sure the authorization has been approved. If no approved authorization is on file, you are responsible for the entire bill.

Billing: Know your insurance policy. You are responsible for any rejected claims, non-covered expenses, deductibles, co-insurance/co-payments. Our statements are sent monthly. Cash, check, money order or all major credit cards are acceptable means in which to pay the balance. If there remains an unpaid balance and we receive no payment or contact from the responsible party despite all our efforts to contact said party, then the account could be turned over to a collection agency or pursued legally. There is a \$25.00 fee for checks that are returned for insufficient funds.

Informing our patients about our financial policy assists us in providing the best service to our patients. Thank you for taking the time to read this policy statement. Should you have further questions or comments, please kindly contact our Business Office Supervisor.

I hereby understand the financial policy of this practice. I guarantee payment of all charges incurred for the account of the patient named below. I further agree to pay any attorney's fees, court costs, and related collection fees incurred. I also agree that my employer may be contacted to verify employment status.

Patient name: _____ Date: _____

Guarantor Signature: _____