# Mount Ogden Eye Center, LLC

## FINANCIAL POLICY

**Thank you for choosing Mount Ogden Eye Center as your health care provider.** Please understand that payment for provided services is due at the time services are rendered. We accept Cash, Checks, and Credit Cards (Visa or MasterCard).

If You Have Insurance

**When we are a Participating Provider** all applicable Co-payments, Deductibles, Lens Fitting, and Refraction charges, which are **NOT** covered by your Insurance Company, are due at the time the service is provided. ***Refraction*** tests are $30.00 and are necessary to determine if your eye prescription has changed, or if glasses will be necessary to correct your vision. Medicare and many supplemental insurances do NOT cover this test. All non-covered services, such as refraction testing will be the responsibility of the patient.

**When we are not a Participating Provider** the patient is fully responsible for all charges. We will bill your Insurance Company, however, the remaining balance of the bill is your responsibility, whether or not your insurance company pays. We will not bill your Insurance Company unless you provide an original claim form. Your Insurance policy is a contract between the Insurance Company and yourself. Please note that some, perhaps all of the services provided may be non-covered under the Medicare Program. If you receive a billing statement from us, or our billing company, we require payment within 15 days from the date of the statement.

### Interest and Collection Fees

We reserve the right to charge interest in the amount of at least 1.5% per month. Accounts over 60 days old will accrue interest charges. In addition a collection cost of at least 40% of the original balance may be assessed to your account should the matter be referred to a collection service. We also will charge a $25.00 returned check fee and any additional collection expenses incurred to recover the original amount due for the medical services rendered.

I have read the Financial Policy of Mount Ogden Eye Center. I understand and agree to these terms.

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Signature of Patient or Financially Responsible Party Date

_____ _____

Signature of Witness Date