

# McMILLIAN EYE CARE

## CREDIT POLICY

### SERVICES:

1. PAYMENT IS REQUIRED ON THE DAY OF SERVICE WITH THE FOLLOWING EXCEPTIONS:
  - A. SPECIAL ARRANGEMENTS HAVE BEEN MADE WITH THE ACCOUNTS MANAGER, OR
  - B. THE PATIENT HAS MEDICARE OR MEDICARE/MEDICAID.
    1. **MEDICARE DEDUCTIBLE:** MEDICARE REQUIRES YOU PAY A FEE EACH YEAR
    2. **MEDICARE CO-PAY:** MEDICARE REQUIRES YOU TO PAY 20% OF YOUR APPROVED CHARGES AFTER YOUR DEDUCTIBLE HAS BEEN MET.
  - C. THE PATIENT HAS COMMERCIAL INSURANCE, PAYS ALL CHARGES FOR THE DAY UP TO \$100.00, ASSIGNS BENEFITS TO THE PHYSICIAN AND AGREES TO PAY THE REMAINING BALANCE NOT PAID BY INSURANCE 30 DAYS FROM THE DATE INSURANCE IS FILED BY OUR OFFICE.
2. ANY BALANCE REMAINING AFTER INSURANCE SHOULD BE PAID IN FULL WITHIN 30 DAYS OF THE DATE OF SERVICE. IF THE PATIENT OR RESPONSIBLE PARTY IS UNABLE TO PAY THE ACCOUNT IN FULL, THEY SHOULD CONTACT OUR ACCOUNTS MANAGER IMMEDIATELY FOR **CONVENIENT TERMS**. (ANY ACCOUNT BALANCE REMAINING UNPAID AFTER 90 DAYS FROM THE INITIAL BILLING DATE WILL BE SUBJECT TO TRANSFER TO A COLLECTIONS AGENCY. THE PATIENT OR RESPONSIBLE PARTY WILL BE REQUIRED TO PAY ANY EXPENSES INCURRED DURING THIS COLLECTIONS PROCESS.)
3. PATIENTS SHOULD ALSO UNDERSTAND THAT THE PHYSICIAN HAS THE RIGHT TO REFUSE FURTHER TREATMENT OF CLIENTS THAT REFUSE TO HONOR THEIR FINANCIAL RESPONSIBILITIES WITH THE CLINIC.
4. THE RESPONSIBLE PARTY WILL ACCEPT FULL RESPONSIBILITY IF THE PATIENT IS A MINOR (UNDER 18 YEARS OF AGE).

I HEREBY REQUEST THAT PAYMENT OF THE AUTHORIZED INSURANCE BE MADE DIRECTLY TO McMILLIAN EYE CARE. I AUTHORIZE McMILLIAN EYE CARE TO ACT AS MY AGENT TO HELP ME DETERMINE AND OBTAIN BENEFITS FROM MY INSURANCE COMPANY. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO MY INSURANCE COMPANY, ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS. I **AGREE TO PAY ALL** COLLECTION EXPENSES INCURRED IN CONNECTION WITH THIS ACCOUNT.

### CONTACTS:

ALL ORDERS MUST BE **PAID IN FULL** BEFORE DELIVERY.

I HAVE RECEIVED A COPY OF THIS CREDIT POLICY AND AGREE TO COMPLY WITH ALL POLICIES. I AGREE TO PAY ALL COLLECTION EXPENSES INCURRED IN CONNECTION WITH THIS ACCOUNT.

\_\_\_\_\_  
PRINT NAME

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE/RESPONSIBLE PARTY