EYECARE ASSOCIATES
OF SOUTHERN OREGON, P.C.

Form good until _____

Patient's Name_____ Date of Service _____
(Please print)

It is our office policy to inform you of our patient payment procedures. Please review and initial the section below that is applicable.

_____ 1. **Patient without Insurance (Private Pay)**

Please make payment for your care at each visit. If payment cannot be made at each visit, arrangement must be made with our billing department prior to your appointment.

_____ 2. **Patient with Insurance**

You are responsible for deductibles, co-pays, non-covered services, co-insurance, and items considered "not medically necessary" by your insurance company. Please pay co-payments and co-insurance amounts as services are rendered. The remaining balance should be taken care of within one (1) month of notice from insurance company unless other arrangements are made with our billing department. If you or your insurance carrier makes payment exceeding your balance, reimbursement will be remitted. If payment cannot be made at each visit, notify the billing department to make other arrangements.

_____ 3. **Medicare**

Our office will submit your Medicare charges to Medicare and your secondary insurance. You are responsible for deductibles, copays, and any non-covered services.

I have read and agree to the Financial Policy Information stated above that applies to me.

_____ _____
Patient or responsible party signature Date

_____ _____
Person signing on behalf of patient (please print name) Reason patient is unable to sign

_____ _____ _____
Relationship to patient Address Phone

Brian K. Mitchell, O.D. **Tessa C. Johnston, O.D.** **Kurt Wilkening, O.D.** **Damon Hanson, O.D.**

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