19052 R.H. Johnson Blvd.
Sun City West, AZ 85375

ARIZONA EYE INSTITUTE
& Cosmetic Laser Center

10701 West Bell Road
Sun City, AZ 85351

FINANCIAL POLICY

We want to thank you for choosing the Arizona Eye Institute & Cosmetic Laser Center as your healthcare provider. We are committed to providing the highest quality optical goods and eyewear possible. We also wish for you to know that payment of your bill for services and products is considered a part of your overall treatment. The following statement explains our Financial Policy, which we ask you to read, sign and return to us. If you choose not to sign this form, please note that you will be bound by the terms and conditions of our practice financial policy.

- All patients should provide accurate and complete personal and insurance information prior to being seen.
- All applicable co-pays, deductibles, personal balances, both current and prior are due at the time of service.
- We accept cash, credit cards (VISA, MasterCard, American Express & Discover) and checks with acceptable proper identification.

Medical Insurance/ Vision Plans

We participate in many insurance and vision plans, and we will be happy to identify whether or not your plan(s) participates with our practice. For some other insurance plans we accept assignment of benefits, but in all cases we require that the guarantor, the person who is financially responsible, is **personally** liable for all balances not covered by your insurance. It is your responsibility to understand and comply with any predetermination of benefits or referral requirements. Please be aware that some, and perhaps all, of the services provided may be non-covered services and may not be considered medically necessary under the Federal Medicare Program or by other medical insurance companies.

Usual and Customary Rates

We are committed to providing the best treatment for our patients and we charge what we believe to be reasonable and customary fees for our region and specialty. If your insurance company uses a different fee schedule and if our practice is not a participating contracted provider, you will be responsible for any balance remaining. Our policy is to charge a fee for copying, faxing and/or mailing copies of medical records. Please ask for exact cost based upon your specific quantity of records and any applicable administrative or postage fees. Our policy is to charge for medical forms, reports, written attestations and the like (e.g. DMV form, disability form, etc.) which are to be signed by our doctor(s).

Missed Appointments

Please help us to serve you and all other patients in a professional and efficient manner. If you fail to keep an appointment or to cancel at least 24 hours in advance prior to your scheduled appointment, you deprive other patients for the opportunity to be seen and cause a financial impact on the practice. We reserve the right to charge a fee of $50.00 for missed appointments or those not canceled at least 24 hours prior to the scheduled time. This fee is not covered by insurance so it will be your personal responsibility.

Past Due Accounts

Overdue accounts which have not been paid within 30 days of the bill date will be charged a monthly late fee depending on how many days the account is overdue. Such accounts will be referred to an outside collection agency when it is determined by the practice that acceptable payment will likely not be made. Once an account is turned over to collections, you may need to contact the agency to resolve your outstanding balance. Unsettled or unpaid accounts that are turned over to a Collection Agency will be assessed a $100.00 fee.

Refunds

All credit card transaction refunds will be refunded to the original transaction credit card and will be charged a 3% processing fee to be applied to the refund amount.

Returned Checks

For personal checks that are returned as unpaid or refused by your bank, we will charge a $50.00 processing fee in addition to the balance due for personal checks that are returned as unpaid or refused by your bank. If the check is not made good in an acceptable period of time, we will forward to the County Attorney's Fraud Division for prosecution under the law.

I have read the Financial Policy. I understand and agree to the Financial Policy in its entirety.

_____ _____ _____

Printed Name Signature Date