Financial Policy

Terms: This is an agreement between Gunderson Eyecare, P.C., as creditor, and the Patient/and Responsible Party named on this form, as debtor. In this agreement the words "you, your, and yours" mean the Patient/and Responsible Party. The word "account" means the account that has been established in patients or responsible party's name to which charges are made and payments credited. The words "we, us, and our" refer to Gunderson Eyecare, P.C. By executing this agreement, you are agreeing to pay for all services that are received.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, if any, and any payments or credits applied to your account during the month.

Payment options if you have no insurance:
1. You may choose to pay by cash, check, debit card, Visa, MasterCard, Discover Card, Amex Card, care credit, HSA, or FSA on the day that treatment is rendered.
2. On products ordered especially for you such as glasses and contact lenses, you may choose to pay 50% at time of order and the remainder of the bill at the time of delivery.

Payment options if you have insurance:
1. You may choose to pay your deductible and any out-of-pocket portions at the time services are rendered by cash, check, or credit card and request that we submit a claim to your insurance company.
2. You may choose to pay all of your treatment by cash, check, or credit card and request your insurance carrier to send their payment directly to you.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued.

Contracted Insurance: If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay or deductible, you must pay that at the time of service. It is the insurance company that makes the final determination of your eligibility. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company and you will be responsible for the additional amount.

Non-contracted Insurance: Insurance is a contract between you and your insurance company. We are not party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company and you will be responsible for the additional amount.

Finance Charge: A finance charge will be imposed on each item of your account which has not been paid within (30) thirty days of the time the item was added to the account. The **FINANCE CHARGE** will be computed at the rate of one and one half percent (1.5%) per month or an **ANNUAL PERCENTAGE RATE** of eighteen (18%) percent. The finance charge on your account is computed by applying the periodic rate (1.5%) to the "overdue balance" of your account. The "overdue balance" of your account is calculated by taking the balance owed thirty (30) days ago and then subtracting any payments or credits applied to the account during that time.

The Financial Policy continues on the back side of this page. A signature is required.

Required Payments: Any co-payments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we cannot bill you for these.

Returned checks: There is a fee (currently $25) for any checks returned by the bank.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer's fees which we incur plus all court costs. In case of a lawsuit, you agree the venue shall be in Dubois County, Indiana.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if you're past due status is reported to a credit agency, the fact that you received treatment at our office may become a matter of public record. You also understand that inquiry may be made by the Responsible Party and statements may be issued to the Responsible Party, and you hereby consent to disclosure to the Responsible Party if the Responsible Party is not also the Patient.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account if said party was responsible at the time the charges were incurred. After a divorce or separation, the parent authorizing treatment for a child will be the party responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Transferring Records: You will need to request record transfers in writing. A reasonable copying fee will be charged for some record transfers. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Worker's Compensation: We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to a personal injury case.

Co-signature: If this or another Financial Policy is signed by another person, that co-signature remains in effect until cancelled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Patient Signature or Parent/Guardian Signature: _____

Printed Patient's Full Name: _____ Date: _____/_____/_____