SLUSHER EYE CENTER
FINANCIAL POLICY

We are committed to providing you with the best possible care. Please understand that payment of your bill is considered part of your care. The following is a statement of our FINANCIAL POLICY which we require that you read, agree to and sign prior to any treatment. We accept cash, checks, money orders, and Visa/Master Card. Extended payment plans are available with prior approval.

MEDICARE/MEDICAID
As participating providers for these programs, we accept assignment of benefits and will file all insurance claims for you. You are responsible for full payment of any deductible, any non covered services, and/or co-insurance at the time services are rendered.

HMO/PPO AND OTHER MANAGED CARE
We will file all insurance claims for you. It is your responsibility to present your insurance card, referral form(s) or number(s) prior to service being rendered. If you require the services of Dr. Slusher and he is not a participating provider for your managed care plan, you will be held responsible for full payment of your bill. Also, payment of applicable deductibles, any non covered services, and co-payments is due at the time service is rendered. At the time of my office visit, I understand my insurance benefits will be verified. If I am not eligible for services at the time services are rendered, I am liable for all charges in full for services rendered.

U.C.R. (USUAL AND CUSTOMARY RATE)
Our practice is committed to providing the best possible treatment and we charge what is usual and customary for our area. You are responsible for paying the bill in full regardless of the insurance company's determination of usual and customary rates.
EXCEPTION: Contractual agreements.

Payment in full is due at the time of service.

DELINQUENT ACCOUNTS
Accounts that are not paid in full or satisfactory arrangements made at the time services are rendered are considered delinquent. Delinquent accounts may be referred to a collection agency, nationwide credit bureau or to our attorney for further action.

Thank you for understanding our FINANCIAL POLICY. Please let us know if you have any questions or concerns.

I have read, understand and agree to the above FINANCIAL POLICY.

_____ _____
Patient or Responsible Party Date

_____ _____
Witness Date