

**AUKER EYE INSTITUTE  
FINANCIAL AGREEMENT**

Dear Patient,

Thank you for choosing Auker Eye Institute as your eye care provider. The following is our Financial Policy, which will help you with your concerns regarding our billing and payment procedures.

Payment for services is due at the time service is rendered. We accept cash, checks, debit cards, MasterCard and Visa. **IF YOU HAVE A CO-PAY, IT WILL BE COLLECTED AT THE TIME OF SERVICE.**

**You are responsible for knowing your insurance benefits.** What are covered services in your plan? Does your insurance require a Primary Care Physician (PCP) referral? Does your physician participate in the plan? **If you are an HMO member, you are responsible for obtaining referral/authorizations from your PCP and/or carrier.** Patients are responsible for deductible balances, co-insurance and non-covered amounts **at the time of service.** Any billed balances are due within 30 days of the statement date.

Please have **ALL INSURANCE CARDS AVAILABLE FOR PHOTOCOPYING AT ALL TIMES.** Any changes of insurance, address, phone number or emergency contact information should be reported immediately.

We appreciate the opportunity to exam and care for your eyes. In the world of health insurance, Medicare and most other carriers will **NOT COVER THE REFRACTION PART OF THE EXAM.** This part determines whether your vision can be improved or not with glasses and is needed to dispense glasses or obtain approval for ANY surgery. **Therefore, we want you to be aware there is a \$55.00 fee for the refraction testing due at the time services are rendered.** If you have any questions please feel free to ask.

**Remember that insurance authorizations/referrals for service do NOT guarantee payment. If your insurance does not pay within 60 days, we ask that you contact them as charges will then be transferred to you. We require you to pay the balance due even though your insurance carrier may eventually process your claim. A refund will then be mailed to you. There will be a \$25.00 fee for all returned check items. Should your account become delinquent and be referred to a collection agency, you shall be financially responsible for the costs of collection and/or legal fees.**

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I request that payment of authorized **Medicare/or any third party** benefits be made to the Auker Eye Institute on my behalf for any services rendered to me. I authorize any holder of medical information about me to release to the center for Medicare/Medicaid Services and its agents or any third party payor any information to determine these benefits or the benefits payable for related services.

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Signature of Patient/Responsible Party

Date