CHEROKEE EYE GROUP

A MEMBER OF VISION SOURCE®

JOYCE M. NATIONS O.D., M.P.H, • LEIGHANN M. KURTH O.D.

FINANCIAL POLICY - ALL PATIENTS MUST READ AND SIGN:

1. All professional fees must be paid in full when services are rendered. We accept, cash, checks, and most major credit cards.
2. Glasses and contact lenses are custom-made items. Therefore, **WE DO NOT GIVE REFUNDS OR CHANGE AN ORDER ONCE THE ORDER HAS BEEN PLACED.** When ordering any glasses or contact lenses you must pay in full at the time of the order.
3. All insurance plans must be pre-authorized before your appointment. At least 48 hours will be needed to determine eligibility. Discount plans are applied at the time of service. If insurance information is not provided 48 hours in advance, you will be required to pay in full for all services rendered or reschedule your appointment. **NO REFUNDS OR CREDITS WILL BE ISSUED.**
4. There will be a $35.00 fee for all returned checks. We do prosecute on all returned checks.
5. Primary insurance will be filed for you if we are an in-network provider. We do NOT file any secondary insurance. Any balance remaining from primary insurance is the patient's full responsibility.

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Signature of Patient or Parent (Guardian) Date

INSURANCE INFORMATION:

I, the undersigned, hereby assign all insurance benefits directly to Cherokee Eye Group, Inc.. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Cherokee Eye Group, Inc. to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

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Signature of Responsible Party Date

MEDICARE/MEDICAID AUTHORIZATION:

I request that payment of authorized Medicare/Medicaid or any other insurance benefits are made to Cherokee Eye Group, Inc. for any services provided. I authorize the release of medical information to the Centers of Medicare and Medicaid Services (as its agent) for information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the CMS-1500 form, my signature authorized release of the information to the insurance agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the fees as determined by the medical carrier as the full charge and the patient is responsible for any deductible, coinsurance and non-covered services. My insurance may not approve the services provided today and I understand that I will be responsible for any claims not paid. I UNDERSTAND THAT THERE WILL BE A $30.00 REFRACTION FEE THAT IS NOT COVERED BY MEDICARE AND IS DUE FROM ME AT THE TIME OF MY EYE EXAM.

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Signature of Responsible Party Date

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