COMPLETE EYE CARE

MEDICAL • SURGICAL • OPTICAL

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Patient Policies & Financial Responsibility Acknowledgement

CANCELLATION AND "NO SHOW POLICY": Patients are expected to cancel at least 24 hours in advance of their scheduled appointments. This notification is necessary in order to adequately allow us to reschedule you and/or fill your spot. NOTE: If you cancel an appointment on the same day of your appointment or fail to come to your appointment, you may be charged a No Show Fee of $25.00.

dfasd_____(Please initial that you have read and fully understand the policy)

REGISTRATION/CHECK-IN: At the time of registration, and periodically thereafter, you will be asked to review your Registration Form. This will help our team keep insurance information and demographics accurate. You will be asked to present a photo ID and current insurance card when you check in for each appointment. Any past due balance will be collected at the time of check-in. Patients under the age of 18 must have a parent or legal guardian in attendance at their appointment.

_____(Please initial that you have read and fully understand the policy)

PAYMENT POLICY: Copayments are due at each visit prior to seeing the provider. You are responsible for knowing your insurance benefit coverage including whether your insurance provider considers our physicians to be "in network". Your deductibles or co-pays may be higher as a result if we are not "in network". If you are a **SELF PAY patient** (not using insurance) payment is due at time of service.

We accept cash, check and certified check, credit cards, debit cards, and FSA/HSA cards. A 3% surcharge will be applied to any credit card payments. There will be a $25.00 fee for all returned checks.

If you need any forms or special reports (ie: DMV, FMLA, or Disability): there is a form fee of $20.00; the fee must be paid prior to the physician completing the forms. The fee for a DMV form will be waived if completed as part of an appointment.

I have read the above Office Payment Policy and as a patient, legal guardian of a minor, or impaired patient, I understand that I am financially responsible for payment on my account. I understand that copayments and contact lens fees are due at time of service. I am also aware that delinquent accounts are subject to other collection means at my own expense including legal fees.

_____(Please initial that you have read and fully understand the policy)

*We now offer patients the ability to bi-directionally text with us at 314.395.9613! Text messaging is HIPAA compliant through a program called OhMD. Message and data rates may apply, depending on your mobile phone service plan. You may also reply STOP anytime to unsubscribe. *Please note, appointment reminder text messages may come from a different number and you can reply STOP to unsubscribe to those as well**

I consent to receive text messages from Complete Eye Care ☐ YES ☐ NO Cell number:_____

_____(Please initial that you have read and fully understand the policy)

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