Great Lakes Eye Institute

Financial Policy

Thank you for entrusting your ophthalmology needs with Great Lakes Eye Institute; we strive to provide the best possible ophthalmic care to each of our patients.

As a service to our patients, we do participate with many insurance plans. We are bound by the policies and procedures required by the insurance plans we have signed an agreement with.

To successfully submit all insurance claims, it is essential that our patients adhere to the following:

1. At each visit, present all current insurance cards; if you would like us to bill an insurance carrier, we must see your current insurance card for that carrier.
2. Please confirm your current address, phone number, and email address as shown on the Patient's Face Sheet presented at the front desk; **we do require social security numbers.**
3. If your insurance carrier requires a referral or prior authorization, please take the initiative to obtain this before your appointment to avoid the inconvenience of rescheduling your appointment or being fully responsible for all charges.

Patient Financial Obligation

4. Outstanding patient balances are due as outlined on the patient statement sent to the patient's home; payment may be made in the office, mailed, or credit card payments taken over the phone.
5. All existing patient balances are expected to be paid in full at time of check-out after an appointment.
6. Co-payments, co-insurances, and deductibles must be kept current and paid as the balance is determined to be that of the patient.
7. Delinquent accounts are subject to further collection action if sent to the collection agency/credit bureau.
8. We do accept cash, checks, Master Card and Visa credit cards.
9. Should a check be returned for non-sufficient funds, a $40 fee will be added to the patient's balance.

My signature below represents that I have read and do understand what is expected of me regarding my financial responsibility for the care provided to me at Great Lakes Eye Institute.

_____ _____

Patient's Printed Name Date of Birth

_____ _____

Patient/Parent/Guardian's Signature Date

03/21/24 sls