French Eye Care Center, PLLC **Financial Policy** **304-586-0970**
103 Roosevelt Blvd. Ste. C **304-586-3744 Fax**
Eleanor, WV 25070

This is an agreement between French Eye Care Center, PLLC, a medical practice, as Creditor, and the Patient/Debtor signing this form.

In this agreement the words "you," "your," and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to French Eye Care Center, PLLC.

By executing this agreement, you are agreeing to pay for all services that are received.

Assignment of Benefits: I request that payment of all authorized insurance benefits be made on my behalf to French Eye Care Center, PLLC. I authorize any medical information to be released to the insurance and any of its agents needed to determine these benefits.

Contracted Insurance: If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay or deductible, you must pay that at the time of service. It is the insurance company that makes the final determination of your eligibility. If your insurance requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company and then becomes your responsibility.

Non-contracted Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract. We will bill your primary insurance as a courtesy to you. Although we may bill your insurance, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company and then becomes your responsibility.

Non-Covered Services: You are responsible for any/all services determined by insurance plans not to be covered. Examples of non-covered services may include, but are not limited to, refraction or external photography performed by us that are necessary for your continued eye health.

The Financial Policy continues on the backside of this page:

Patient's name: «Patient_First_Name» «Patient_Middle_Name» «Patient_Last_Name»

Signature of Patient or Responsible Party **«Current_Date»**

Payments: Unless we approve other arrangements in writing, the balance on your statement is due and payable by the 20th of the month the statement was issued.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time if an unpaid balance remains. Future visits would then need to be paid at the time of services rendered.

1.5% per month/ 18% per year or $2.00 per statement fee. The finance charge on your account is computed by applying the periodic rate (1.5%) to the "overdue balance" of your account. The "overdue balance" of your account is calculated by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show any charges to the account, the late fees/statement fees, if any, and any payments or credits applied to your account during the month.

Statement Fee: A statement fee of $2.00 per statement may be imposed on each account that is over thirty (30) days past due. We determine your account is past due by taking balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time.

Credit History: You give us permission to check your credit and employment history and to answer questions about your credit experience with us. We have the option to report your account status to any credit reporting agency such as a credit bureau.

Returned Checks: There is fee (currently $25) for any check returned by the bank.

Missed Appointments: Patients who do not show up for an appointment, or cancel with less that 24 hours notice will be charged the amount for the procedure that the patient was scheduled for beginning at eighty ($80) dollars. The fee must be paid before a new appointment is scheduled.

Past due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs, which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees, which we incur, plus all court costs. In case of suit, you agree the venue shall be in Putnam County, West Virginia.

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.