FINANCIAL POLICY AND PATIENT SIGNATURE ON FILE

At Dr. Todd Wild's Optometric office your care and a positive outcome are our first priority. We are providing this payment guideline information to assist you in meeting your financial responsibilities linked with your care at our office.

ARRANGING PAYMENT

Payment is expected at the time of service. Your glasses are a special order item because they are made to your individual prescription needs. As a result, they require a deposit of 1/2 down at time of order, with the balance to be paid at time of dispense. We accept cash, check or credit card.

Minor patients: The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non emergency treatment will be denied unless charges have been pre-authorized. In a situation of divorce, the parent bringing in the dependent child for services will be the parent billed and held responsible for any and all charges incurred. This is regardless of the divorce decree.

REGARDING INSURANCE

We may accept assignment of your Insurance benefits. However, most insurance companies do not cover at 100%. We require that your portion of the bill be paid at the time of service. The balance is also your responsibility whether your insurance pays or denies. If you are unable to clear your balance within 30 days, a minimum of 1/3 of the balance due is required as monthly payment.

We cannot bill your insurance unless you give us a copy of your current insurance information and authorization. Your insurance is a contract between you and the insurance company; we are not a party to that contract. If you need a referral for your visit, it is your responsibility to obtain one from your primary care physician prior to our services.

INTEREST AND BILLING CHARGE

We reserve the right to assess a $1.00 billing charge of 1.5% Interest (whichever is greater) on balance of 30 days or older.

If your account goes into a delinquent state by not having made consistent payments and or other finical arrangements with our office on your account, you will be notified if by mail to call our office and pay on account and if you do not comply within 30 days of that notice your account may be sent to collections and you will be billed an additional 33.3% of the delinquent balance. This is the percent we are charge by Credit Systems of the Fox Valley to recoup finances in our behalf.

I understand & agree to this financial policy. I hereby authorize payment of medical benefits to Dr. Todd W. Wild for any services provided to me. I understand that I am responsible for any difference in the amount billed and the amount paid by my Insurance. I authorize the release of any medical information necessary to process claims process on my behalf. This authorization is in effect indefinitely.

SIGNATURE_____DATE_____

RESPONSIBLE PARTY/PARENT OF MINOR

PATIENT NAME_____