COMPLETE EYE CARE

FINANCIAL POLICY

We are committed to providing you with the highest level of service and quality care. If you have medical insurance, we will strive to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our financial policy. Ultimately all financial liability rests with the patient.

INSURANCE AND PAYMENT AGREEMENT

I authorize Medicare and/or my private insurance company to pay Wesley J. Harnish, MD dba Eye Surgical & Medical Care for all services provided to me.
I will bring all current insurance information to each office visit and notify the office immediately of any changes to my coverage.

I am responsible for knowing and complying with the requirements and restrictions of my insurance plan.

If my insurance plan requires a referral to seek care from a specialist (Dr. Harnish and his associates are specialists,) I will obtain it prior to my scheduled appointment.

In accordance with my insurance contract, I will pay all co-payments and deductibles on the day I receive service.

Any portion of my bill that is "patient responsibility" and is billed to me will be received by the due date printed on the statement (term 30). If the balance is not received by the due date a $25.00 statement fee will be added to my account and due immediately.

Any payment made by check that does not clear my bank will be assessed a $50.00 fee, which will be added to my account and will be due immediately.

I understand that any outstanding balance considered past due will be processed for collection. An account recovery fee of $50.00 will be added to my balance sent to collection. A collection account may be sent to a collection agency and reported to the appropriate credit bureau(s).

I understand that by signing below, I agree to these terms for the duration of my relationship with Wesley J. Harnish, MD. dba Eye Surgical & Medical Care.

Patient/Guardian Signature:____

Wesley J. Harnish, MD
Tatiana Hammond, OD
Mary Furgerson, OD

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