We're good for Eyes™

CARROT EYE CENTER

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480-561-6000
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Carrot Eye Center Financial Policy

This is an agreement between Carrot Eye Center, as a creditor, and the Patient/debtor named on 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 Carrot Eye Center.

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

Refractions: Refraction is the process of determining the eye's refractive error or need for corrective spectacles or contact lenses. It is an essential part of an eye examination, but is not a covered service by Medicare or most insurance's. If it is not a covered benefit through your insurance, you will be billed a $50 refraction fee.

Disability/FMLA Forms: There will be a $25.00 fee for the completion and processing of all disability and FMLA related paperwork. Please also allow 5-7 business days for these to be completed.

AZDOT MVD Forms: Fee $60 for completion and service

Insurance: Carrot Eye Center provides services to you, not your insurance company. Because of this fact, you are responsible for payment of any bill incurred in this office. As a courtesy to you, we will bill your primary and secondary insurance company. If we have not received payment from your insurance within 60 days of service, you will be responsible for paying your balance in full. You are responsible for all deductibles and charges not covered by Insurance. Please understand that as a third party, we cannot become involved in a prolonged insurance negotiation. That is your responsibility. Please contact your insurance company to inquire if we are a participating provider. All required co-payments must be made at the time of service. We accept cash, personal check, and most major credit cards. If you have medical insurance but are unable to provide a copy of your insurance card, you will need to pay for your exam on the day of service. A day of service discount will be applied.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show each date of service, a description of the services rendered, the charges, any payments made by you or your insurance, and your current balance.

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

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

Divorce: In the case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible of the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Self-Pay: You are responsible for the full amount of the exam. A day of service discount will be available, only if you pay on the day of service. Otherwise you will be responsible for the full amount of the exam and will not receive the day of service discount.

Liabilities: In the event that payment in full for charges incurred was not made, patient and the undersigned, if other than the patient, each jointly and severally agree to pay interest at the rate of 18% annually on all past due balances from the original due date, plus court cost and reasonable attorneys' fees, with or without suite, incurred in collecting any past due balance, and a collection fee if my account is assigned to a collection agency. I authorize the release of financial identifiable information concerning my account (including charges billed, payments made, and interest charges assessed, etc.) to the physician's collection agency or collection attorney should collection procedures as described become necessary.

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

I certify that I have accurately filled out the patient and insurance information form. I grant my permission to Carrot Eye Center and their assignee to telephone me at home or at my workplace to discuss matters relating to the Financial Policy. I certify that I have read and understand the Financial Policy and I hereby agree to abide by the conditions outlined therein.

Acknowledgement: Receipt of Carrot Eye Center's Notice of Privacy Practices:
I acknowledge that I received the Notice of Privacy Practices from Carrot Eye Center.

Signature of Responsible Party:_____ Date: _____

Patient's name (please print): _____

Responsible Party's Name (if not the patient): _____

Signature of Responsible Party: _____ Date: _____