McElhinney Eye Care, PA
Financial Policy

Thank you for choosing McElhinney Eye Care, PA. We strive to provide the highest quality eye care possible. Paying for our services in a responsible and timely manner is appreciated by our practice.

Our financial policy is listed below. We ask that each patient read and sign a copy of this policy. Please read this statement, sign the bottom, and should you have any questions please feel free to contact our billing department.

Acceptable Payment Methods:
We accept cash, checks, Visa, MasterCard, Discover and American Express. Payment is expected at the time of service.

Insurance: Our office accepts assignment of benefits from many insurance companies, HMO and PPO programs. However, we do not participate with all benefit programs. Please contact the customer service department of your insurance company to verify that our physician participates with your plan.

Affordable Care Act Insurance: Our office participates with a limited number of plans from the Affordable Care Act. Please call the customer service department of your insurance company to verify that our physician participates with your plan.

We do require that co-payments, deductibles and any non-covered services, which include refractions and contact lens charges, be made at the time of service. If our practice does not participate with your insurance plan we require payment in full at the time of service.

Your bill is your responsibility: Most insurance companies do not provide full coverage and it is your responsibility to pay the balance. Payment in full is due within 90 days of being notified of any balance. It is our policy to mail out three billing statements. Failure to pay the balance in full or contact our office regarding a payment plan will result in your account being transferred to a collection agency.

I have read and understand the "Financial Policy" and agree to all terms and conditions stated above. I understand it is my responsibility to verify my medical coverage with my insurance company. I understand that I am responsible for any unpaid balances by my insurance company.

Signature:_____**Date:**_____

Print Name:_____

09/19