Tracey Dexter, OD
2 09 West 15th Street
Hopkinsville, KY 42240
270-886-8129

FINANCIAL POLICY

Thank you for choosing us as your eye care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy which we require that you read, agree to and sign prior to treatment. All patients must complete our Patient Information Form before seeing the doctor.

OFFICES SERVICES: If you have insurance and the deductible has not been met, payment is expected at the time service is rendered. If the deductible has been met, the co-pay or non-covered amounts are expected. If you are uninsured, payment is due at time of service.

OTHER INSURANCE AND THIRD PARTY PAYMENTS: Responsibility for payment is your obligation regardless of insurance coverage. We are pleased to assist you in preparation of your insurance claim forms. We cannot guarantee payment of your claims. Reduction or rejection of the claims does not relieve your financial obligation. If the deductible has not been met, payment is expected at the time service is rendered. If the deductible has been met, the co-pay or non-covered amounts are expected at time service is rendered.

MINORS: The adult accompanying a minor and the parents (or guardians) are responsible for payment of the minors account. Many times the question of financial responsibility is complicated. Our policy is that the parent requesting treatment for minor child is responsible for all fees incurred.

CASES INVOLVING LITIGATION (i.e. auto accidents, altercations, etc.): We consider the patient, and not the attorney, to be the responsible party for all fees.

DISABILITY FORMS: Disability forms can be very time consuming to research and complete. For this reason, a $20.00 charge will be made for each form.

RETURNED CHECKS: A $50.00 fee is charged for each check returned to us.

STATEMENTS: All charges are due and payable within 45 days of the time the services are rendered. If your insurance company has not paid your account in full in 45 days, the balance of your account will automatically be billed to you for immediate payment. Please remember that our services are rendered and charged to you, not your insurance carrier.

I acknowledge responsibility for payment for all fees regardless of any insurance I may have to assist me in this responsibility. If for any reason the account should become delinquent, I agree to pay all collection and legal fees.

I have read, understood and agree to the above Financial Policy.

Print Name of Responsible Party _____ Date _____

Responsible Party Signature _____