



Policy on Patient Responsibility for Fees

Thank you for coming to Zdenek Eye Institute. We believe that good care for you and your family starts with good communication, and we have created this policy to help our patients understand the responsibilities that they and their families have for payment of our fees. If at any time you have questions or concerns with our fees or payment process, please don't hesitate to speak with *David* at (818) 708-2222 or *dv@fyeye.com*.

We require that our patients promptly pay all charges that we present to them. If we present a charge to you, it means that we have taken any insurance adjustment and/or discounts into account and that you must pay the amount remaining. If you are reimbursed directly by a program for the cost of your care, you must still pay our charges promptly, whether or not you have received that reimbursement. Additionally, to make it easier for our patients to pay future balances we require a credit card on file, stored securely. If you do not agree with patient responsibility amounts or reimbursement amounts set by your insurance or government program, this is a matter between you and that program. We are happy to provide you with factual information about your care and billing to help you discuss this with them.

Payment for our services is due at the time that those services are provided to you. This includes, among other things, copay amounts, program deductibles, earlier charges that remain unpaid, and charges for services that we believe are not covered by, or are left over as your responsibility to pay after coverage by, insurance or government programs. We or our agents may send you statements and reminders and calls of charges made and amounts that must be paid. By accepting our services, you are consenting to receive these communications.

Discounts may be available for prompt/early payments. Past Due balances may be subject to penalties and interest. If no payments on past due balances are made in 90 days we may place your account with our collections agency. In some instances monthly payment plans may be made with our office manager, please ask for details.

I understand the above information, and I will be financially responsible for the following patient:

Print Patient Name

Signature: also print name, if different from patient

Date