

CORNEAL CONSULTANTS OF COLORADO, P.C.
FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you read and sign prior to any treatment.

All patients must complete our Information and Insurance form before seeing the doctor.

CO-PAYMENT IS DUE AT TIME OF SERVICE.
WE ACCEPT CASH, CHECKS, VISA/MASTER, or DISCOVER.

Regarding Insurance:

We may accept assignment of insurance benefits. Any balance due after your insurance company has paid their portion or denied payment is your responsibility. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We cannot bill your insurance company unless you give us current and correct information which includes a copy of your current insurance identification card, your social security number, your full and legal name and current address. If extended payments are required, arrangements must be made prior to treatment. Please be aware that some, and perhaps all, of the services provided may be non-covered services and are not considered reasonable and necessary under the Medicare Program and/or other medical insurance.

Regarding Insurance Plans where we are a participating provider. All co-pays and deductibles are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to the above paragraph.

Usual and Customary Rates:

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Adult Patients:

Adult patients are responsible for payment.

Minor Patients:

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa/Mastercard, Discover, or payment by cash or check at time of service has been verified.

Miscellaneous fees:

A billing/charge fee of \$15.00 per month will be added to all accounts that are 60 days or more past due. We also charge a \$20.00 fee for all returned checks. Without 24 hours notification a \$25.00 missed appointment fee will be charged. Failure to pay your copay at the time of service will result in a \$15.00 billing charge.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns. I have read the Financial Policy. I understand and agree to the Financial Policy:

Signature of Patient or Responsible Party

Date _____