Eye to Eye Clinic Wilsonville

Dr. Rosiland Hursh and Dr. Lorne Yudcovitch
Optometric Physicians

8269 SW Wilsonville Road, Suite C
Wilsonville, OR 97070

CREDIT POLICY

AS A SERVICE TO OUR PATIENTS, WE WOULD LIKE TO OUTLINE OUR POLICY TOWARD THE PAYMENT FOR SERVICES RENDERED.

1. As a courtesy to you, your PRIMARY INSURANCE will be billed, provided the necessary **ID, Group Numbers**, and **billing address** are provided **at the time of visit**, unless other arrangements have been previously made. **However after 45 days, the balance of the bill becomes YOUR responsibility.**

2. We will be happy to provide you with the information so that you can submit a claim to your secondary insurance. **NO SECONDARY INSURANCES WILL BE BILLED** and you are responsible for your balance after your primary insurance has paid.

3. **Although we are billing insurance companies, we hold you responsible for your account**. We are happy to contact your insurance company to determine your benefit but this is not a guarantee of payment by your insurance company.

4. Any services/materials considered to be **“non-covered benefit”** by your insurance company will be billed to you.

5. Insurance **co-pays** are required at the time of the office visit.

6. We realize that many families are in a state of change. Divorces, separations, single parents, and blended families are now common. In many of those families, the question of who is responsible for the children’s care is uncertain. Our policy is that **the parent who requests treatment** for the child is responsible for all fees incurred.

7. We encourage you to contact our billing/crediting department if you have any questions regarding your account. We will be happy to set up a payment plan with you if needed. Once an arrangement has been made, you will be expected to follow that plan.

8. Your signature authorizes us to contact any reference in case it becomes necessary to locate you.

I HEREBY AUTHORIZE THE ABOVE DR/DRS TO FURNISH THE INSURED’S INSURANCE COMPANY ALL THE INFORMATION WHICH SAID INSURANCE COMPANY MAY REQUEST CONCERNING MY CLAIMS FOR SERVICE.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT COVERED BY MY INSURANCE COMPANY.

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Responsible party’s signature Date