INDIANA VISION
Development Center

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PAYMENT CONTRACT

Dear Patient:

Thank you for selecting us for your vision care needs. We want to prevent any misunderstandings regarding our payment policy, therefore, we request that you read and sign this explanation of our policy.

Dr. Myers will honor Cash, Check, Visa, MasterCard and Discover as payment. The patient is responsible for payment of his/her account at the time services are rendered. We realize in some cases that medical care can be unexpected and costly. In those exceptional situations, our Accounts Manager is ready to discuss acceptable financial arrangements with you prior to leaving the office.

Dr. Myers office submits insurance claims with Medicare. In order for us to bill Medicare, you must present your insurance card prior to your visit. It is the patient's responsibility to resolve any problems that delay or prevent payment of the claim. The patient is also responsible for any co-payments or deductibles or non-covered items at the time services are rendered.

Referral to our professional collection service will be made for accounts older than three (3) months and when the patient has not made firm credit arrangements with our Accounts Manager. In the event of default I agree to pay late fees, collection costs and reasonable attorney fees as may be required in collecting debt.

The undersigned certifies that he/she has read the forgoing and is the patient, patient's guarantor or duly authorized by the patient's agent to execute this agreement and accept its terms.

Patient_____Soc. Sec. No._____

Address_____Date of Birth_____

City/State/Zip_____Home Phone_____

Parent/Spouse/Guardian's Name_____Alt. Phone_____
(Emergency Contact Not Living at Address Above)

Email Address: _____

Employer Name_____Work Phone_____

Spouse's Employer_____ Work Phone_____

Insurance Company Name_____ID#_____

Insured's Name_____Insured's Date of Birth_____

Insured's Employer Phone_____ Insured's Social Security Number_____

Whom may we thank for referring you to our office?_____

_____ _____ _____
Responsible Party Social Security Number Date

Consent of treatment for minors under the age of 18_____
Parent/Guardian Signature

_____
Office Staff Signature