M-Eye Vision

Liching Han, O.D.

6725 South Fry Rd Suite 400, Katy, TX 77494

(P) 281-394-7886 (F) 281-394-7802

FINANCIAL DISCLAIMERS AND POLICY

Your understanding of our financial policies is an essential element of your care and treatment. Please feel free to discuss them with our staff if you have any questions.

Full payment is due at the time of service unless other arrangements have been made in advance either by you or your health coverage carrier. We accept Cash, Visa, MasterCard, Discover, American Express, and Diners Club International.

As a courtesy to our patients, we try to verify your health plan benefits including medical eye care, and optical supplies before you receive any services from us. However, there is no guarantee that your insurance plan will pay in full the services that you are about to receive from us.

We have prior arrangement with most vision insurers and many medical and other health plans. We will bill those plans and will collect any required copayment when you arrive for your appointment.

If your health plan carrier fails to pay in full for the services rendered, you are fully responsible for the unpaid balance which is due upon receipt of a statement from our office.

If you have insurance coverage plan with which we do not have a prior agreement, we will prepare and send the claim for you, on an unassigned basis. In this case, your insurer will send the payment directly to you. So the charges for your care, treatment, and material are due at the time of service.

For medical visits, your major medical plan will be billed and you are responsible for all copays, deductibles, and non-covered services related to your major medical plan.

You authorize your health plan carrier to pay M-Eye Vision directly.

You authorize M-Eye Vision to release any medical and financial information to my health plan carrier in order for them to receive payment for their services.

For all services rendered to minor patients, the adult accompanying the patient is responsible for payment.

There are absolutely no refunds on any professional services or contact lens fitting fees performed by the doctor.

<u>I have read and understand the above financial disclaimer and I have initialed and agreed with all the terms mentioned. I also understand and agree that the terms may be amended by the practice from time to time.</u>

Patient's printed Name: ______________ Patient's Signature: ______________ Date: ______________

If patient is under 18 years of age

Guardian's Printed Name: ______________ Guardian's Signature ______________ Date: ______________