EXCEL EYE CENTER EXCEL COSMETIC SURGERY CENTER EXCEL OPTICAL

FINANCIAL POLICY & AGREEMENT

PATIENT NAME: **DATE OF BIRTH:**

GUARANTOR: The undersigned will be the guarantor of the above listed patient, and will be financially responsible for any balances owed on the account. As the guarantor you are responsible to provide accurate insurance information, within the claim filing time limits of your insurance. You are also responsible to know your benefits and coverage provided by your health insurance, before any services are rendered. We will not assign an ex-spouse as guarantor, regardless of a divorce decree.

PAYMENT: Co-pay(s), co-insurance, and/or deductible amounts are due at the time of service, for those with insurance. Co-payments not paid at time of service will result in a $20 late fee. For those without insurance, payment in full, is due at the time of service and will receive a prompt pay discount. Payment plans may be arranged, at the discretion of Excel Eye Center and Excel Cosmetic Surgery Center.

VISION PLANS: We are not contracted with ANY vision plans.

ROUTINE EYE EXAMS: You are responsible to know if your health insurance does not cover routine eye exams prior to your visit.

GLASSES AND CONTACT LENS PRESCRIPTIONS: All patient's seeking a prescription for lenses will be charged for a refraction, which is a necessary test performed to determine visual acuity. Please be aware that not all insurance plans cover this test. You are responsible to know whether your insurance will cover this test. A $20.00 refraction fee may be due at the time of service.

CONTACT LENS FITTING(S): Payment for fittings is due at the time of service and may vary depending on the type of lens the patient is being fitted for. We will not release contact lens prescriptions unless the fitting was performed in our office, and the fitting fee has been paid in full.

GLASSES AND CONTACT LENS: Payment in full is due prior or at the time of pick-up of glasses and contact lens.

SPECIAL EYE EVALUATION AND TESTING: Some eye conditions require additional testing or examinations, of which you will be charged in addition to your office visit, or post-operative exam.

FOLLOW-UP VISITS: Excel Eye Center and Excel Cosmetic Surgery Center charge for follow-up visits.

RETURNED CHECKS: Returned checks will be charged a $25.00 servicing fee. We reserve the right to refuse checks as a form of payment once a check has been returned on an account.

DELINQUENT ACCOUNTS: Excel Eye Center, Excel Cosmetic Surgery Center, and Excel Optical reserve the right to forward unpaid balances to a third party collection agency. In the event that a balance is not paid as agreed, the undersigned agrees to pay all collection costs. In the event of a lawsuit to collect the unpaid balance, the undersigned further agrees to pay court costs, reasonable attorney fees and interest (both pre and post judgement).

I hereby agree to financial responsibility and am responsible for all co-pays, co-insurance, deductible amount, and/or any services deemed as non-covered by my health insurance. I authorize Excel Eye Center, Excel Cosmetic Surgery Center, or Excel Optical to bill my insurance, and receive any benefits due me to be paid directly to 1735 N State St, Provo, UT 84604. If I am not the patient, I agree that I am authorized to consent to release any information my health insurance requires to pay my claims. In consideration of medical services rendered, I acknowledge that I have received notice of Excel Eye Center, Excel Cosmetic Surgery Center, and Excel Optical's financial policy and agree to pay for said medical services according to such terms.

I hereby consent to being contacted by telephone at phone number (including but not limited to wireless/cellular phone numbers) provided to Excel Eye Center, Excel Cosmetic Surgery, and Excel Optical, by me or anyone associated with me or acting on my behalf. I understand and agree that such calls may be initiated by Excel Eye Center, Excel Cosmetic Surgery, or Excel Optical or any of its affiliates, agents, contractors or assigns, including but not limited to billing companies and/or third party collection agency(ies), and that the methods of contact may include using pre-recorded/artificial void messages and/or the use of an automated dialing device and/or the use of test messages-some or all which may result in data charges. I also consent to receiving e-mails under the same terms at any e-mail address provided by me or anyone associated with me or acting on my behalf. In granting each and all of the foregoing permissions, I understand that I am responsible for ensuring my own level of privacy.

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Responsible Party Signature **Date Signed**

_____ _____

Printed Name of Signee **Relationship to Patient**

Revised 8/8/2019