SOUTHERN EYE GROUP

Biloxi • Fairhope • Foley • Gulf Breeze • Mobile • Pensacola • Saraland • Spanish Fort • South Foley

Salmedina Alic, OD | Donna Corder, MD | Ayesha Kidd, OD | Paul McDaniel, DO | Hong Nguyen, OD | Courtney Ray, MD
Ray Rojas, MD | Gayla Rowland, MD | Dan Wilder, OD | Taylor Wolkart, OD | Peter Zloty, MD

Financial Policy

Thank you for choosing our office to provide your eye care. We appreciate your trust and look forward to working with you. In order to prevent any misunderstanding, and to better serve you, we ask that all patients read and sign our Financial Policy. If you have any questions, please ask.

1. **VERIFYING INSURANCE:** As a courtesy to our patients, we will verify insurance for eligibility benefits prior to the first appointment, as well as any time we are notified of a change in coverage. The insurance companies do not guarantee payment based on the information that they provide us. You are ultimately responsible for knowing if there are any waiting periods for work to be performed. Any amount on your treatment plan that is not covered by your insurance is your financial responsibility.
2. **INSURANCE INFORMATION:** New insurance, as well as changes in insurance, must be provided to our office prior to your appointment. Accepting assignment of benefit from your insurance company is the equivalent of extending your credit; therefore, we must have your Social Security Number on file. If you choose not to provide us with your Social Security Number, you will be responsible for payment in full at the time services are rendered.
3. **CHANGES IN PERSONAL INFORMATION:** Changes in your address or telephone numbers should be provided to us immediately. If this office is unable to contact you by telephone or mail, and your balance is overdue, your account will be sent to a collection agency.
4. **REQUESTS FOR ADDITIONAL INFORMATION:** These must be responded to immediately. Such requests include proof of college student's full-time status and proof of continued enrollment in any insurance plan. Failure to provide this information to the insurance company in a timely manner may result in the entire balance being your responsibly.
5. **PAYMENT:** Payment is due at the time of service. Additionally, if you have a balance following a previous visit, you will be expected to pay that amount as well. If payment is made directly to you for services billed by Bay Eyes, you agree to promptly remit payment to Southern Eye Group (Bay Eyes Cataract and Laser).
6. **PAYMENT PLANS:** In addition to cash, checks, Visa, MasterCard, and Discover, we offer several payment plans – please see staff for details.
7. **REFUNDS:** Overpayments will be refunded to the appropriate party, normally the insurance company or the guarantor. Patients' refunds will not be processed until all active or past due accounts and insurance claims have been paid in full. Any balances of $25 or less will remain on account for one hundred twenty (120) days, and if not used will be adjusted off the account.
8. **RETURNED CHECKS:** There will be a $30 fee for all returned checks. The amount of the check plus the fee must be paid within ten (10) days of notification by money order, cash, or credit card. Once a check is returned, this office will no longer accept a personal check for payment.

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Signature of Patient (or Responsible Party) Date

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Printed Name of Patient (or Responsible Party)