Financial Policy

Thank you for choosing Hertzog Family Eye Care as your eye care provider. We are committed to providing you and your family with the best available medical care. In our ongoing process to make sure that all your medical needs are met, our billing department will be available to discuss our fees and this policy with you.

We ask that all responsible parties read and sign our financial policy as well as complete the patient information prior to seeing the doctor.

Payments for all services will be due at the time services are rendered. In order to serve you better, we accept cash, check, Visa, MasterCard, Discover, and CareCredit. As a courtesy to you, it is the policy of Hertzog Family Eye Care to bill you insurance carrier, although you are ultimately responsible for the entire bill. As the responsible party, please understand the following: (**PLEASE INITIAL**)

\_\_\_\_\_1. Your insurance policy is a contract between you, your employer, and the insurance company. We are not a party to that contract. Our relationship is with you, not your insurance company. We will not become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance and “usual and customary” charge. As your medical provider, we will only supply factual information to facilitate claims.

\_\_\_\_\_2. Fees for service, which include unpaid balances, deductibles and co-payments, are due at the time of service. Returned checks and unpaid balances may be subject to collection placement and collection fees.

\_\_\_\_\_3. All charges are your responsibility whether your insurance company pays or does not pay. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. If any payment is made directly to you for services billed by Hertzog Family Eye Care, you recognize an obligation to promptly remit payment to Hertzog Family Eye Care.

\_\_\_\_\_4. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, after such default and upon referral to a collection agency or attorney by Hertzog Family Eye Care, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

\_\_\_\_\_5. The above does not apply for those patients that are considered Worker’s Compensation. However, be advised that as a compensation patient, you may be held responsible for charges in the event that your claims is controverted.

At Hertzog Family Eye Care, we understand that financial problems may affect timely payment, so we encourage you to communicate any such problems to us, so that we may assist you in keeping your account in good standing. If you have any questions, please call 501-941-2222 in Cabot or 501-985-2020 in Jacksonville.

You agree, in order for us to service your account or to collect any amounts you may owe us, we may call you at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also communicate with you by sending text messages or e-mails to your wireless number or e-mail address. Methods of contact may include using a prerecorded/artificial voice and/or the use of an automated dialing device. These authorizations shall remain in effect until individually withdrawn by you in writing to our facility and/or any others to which authorization has been extended. I have read this disclosure and agree that "your office or agent" may contact me as described above.

**I understand the above information and will be responsible for the patient listed below:**

Printed Name of Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Responsible Party:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_