JENNIFER M. GUDAS, O.D., P.C.
"Complete Family Eye Care"
633 East 13th Street, P.O. Box 365
Winamac, IN 46996
Ph. (574) 946-3944 Fax (574) 946-6843

Payment Policy

Please check one of the following payment options. By checking this option and signing this form you agree to follow this option as described. If you have any questions please contact our office. Thank you!

SPECIAL NOTES:

A. **PAYMENT IS DUE AT THE TIME OF SERVICE OR WHEN RECEIVING MATERIALS.** If other arrangements are necessary, they must be made **PRIOR** to receiving services.
B. **In the case of separated or divorced parents**, whoever brings the child to their appointment is responsible for the bill.
C. **Insurance Patients** – Due to the increasing complexity and variability of the many different insurance plans today, and because more and more of the plans reimburse the patient directly, we are now asking our patients to pay their bill directly to our office. If the insurance payment comes to our office, we will promptly refund the patient. Also, please make sure we have a copy of your current insurance card.

PLEASE CHECK ONE OF THE FOLLOWING PAYMENT OPTIONS:

___1. **CASH/CHECK/CREDIT CARD** – "I will pay in full when my services are rendered. I will pay 50% today for any materials ordered and the balance when I receive them."

___2. MEDICARE PART B – (TRADITIONAL MEDICARE ONLY! WE DO NOT ACCEPT MEDICARE REPLACEMENT PLANS!)"I will pay in full today for any deductibles and extra charges that I owe." NOTE: Our office is not required to wait for the secondary insurance to pay before billing you directly for the unpaid balance.

___3. VSP, EYEMED, VCP, UMR, PBA – "I will pay in full today for any copays, deductibles and any extra charges that I owe."

___4. MEDICAID – "I understand that if Medicaid does not pay for any of my services or materials, I am responsible and agree to pay for them myself."

___5. OTHER VISION INSURANCE – (INCLUDING MEDICARE REPLACEMENT PLANS SUCH AS ANTHEM, HUMANA, AARP) "I have not previously filed this vision insurance in this office; therefore, we are not familiar with the insurance benefits and payments. I agree to pay for all charges in full when my services are rendered as is stated in Option #1 above and will request that the insurance payment come directly to me. If payment is received by this office they will promptly refund me."

Name of your insurance company: _____

I agree to pay all of my charges as promised. I further agree upon default to pay 1.5% per month (18% per annum) on any unpaid balances along with all costs of collection including reasonable attorney fees. I further agree that any dispute with regard to payment of this debt shall be subject to the laws of the State of Indiana and by my signature am submitting myself to the jurisdiction of the courts of Indiana.

_____ _____

Patient's Signature Date