PAYMENT EXPECTATION POLICY

As a courtesy to our patients, we accept multiple different types of insurance plans and submit claims to these plans on your behalf. To do this efficiently, it is important that we have accurate and complete information on your insurance coverage. In addition, it is important that all of your insurance plan's requirements are met prior to providing services. This may include your payment of co-pays, deductibles, and non-covered services at the time of service and that pre authorization or referrals are obtained prior to service.

It is the patient's responsibility to pay for all services provided not covered by insurance. That includes amounts denied or not covered by your insurance plan. We are happy to provide any services you need, but if your insurance plan does not cover this or these service(s), you may be required to sign a waiver form permitting us to bill you for these non-covered services. If we have not received payment from your insurance plan by 30 days after the date of service, or if the insurance plan has denied payment in full or part, we will bill the balance to you. If you are unable to make your appointment we do require a 24 hour notice in order to avoid any cancellation fees.

Payments of co-pays, deductibles and non-covered services are expected at the time of services. Patients without insurance are expected to make payment or make other payment arrangements prior to service. Multack Eye Care accepts the following methods to satisfy your obligation:

--Cash, check or most credit cards. Checks returned for non-sufficient funds (NSF) will be charged $25.00
--Budget plan: make a deposit today and pay the remaining balance over 3 to 6 months.

We will bill outstanding balances to you monthly, and payment is due upon receipt. Account balances that have not been paid within three statement cycles will be turned over to a collection agency. Payment of unpaid balances is expected prior to new service being provided.

I hereby authorize Multack Eye Care and its agents to submit a health insurance claim for any service and receive payment from my insurance carrier if I do not make payment in full for such services. I authorize Multack Eye Care and its agents to release information from my medical record that pertains to filling and providing adequate documentation for any insurance claim. I am aware that if I refuse to consent to this release of information or if Multack Eye Care does not have adequate health insurance information on file for me, the charges incurred will be my responsibility. I hereby state that I have fully disclosed all insurance coverage and the information is true. I understand and agree that I am responsible for payment of all services received from Multack Eye Care not covered by my insurance plan.

Signature of patient (or guarantor if patient is a minor):______________________________

Name of patient or guarantor (Please Print):______________________________

If signed by guarantor, name of patient (Print):______________________________

Patients Date of Birth:________________ Date of Service:____________________

20303 S Crawford Ave, LL1
Olympia Fields, IL 60461
(O) 708.898.1858 (F) 708.898.1860

870 N Convent
Bourbonnais, IL 60914
(O) 779.900.8222 (F) 815.304.4270

22200 Wolf Road
Frankfort, IL 60423
(O) 815.889.3333 (F) 815.277.2505