John D. Kirk, MD, FACS
John W. Colvin, OD
3650 E. 15th St.
Loveland, CO 80538

FINANCIAL POLICY

Welcome to Kirk Eye Center. Please take a few minutes to review the following information prior to your appointment.

We hope you understand that our financial policies are established to assure the financial resources needed to maintain this medical office for all our patients. We will work with you to ensure that your medical care does not become a financial burden.

- **Charges for medical services are due and payable at the time of service**. We accept cash, personal checks, and most major credit cards for payment of your account.

About health insurance:

- Your insurance policy is an agreement between you and your insurance company. Our relationship is with you, **not** with your insurance company. Therefore, all charges are ultimately your responsibility, regardless of your insurance status.

If you have health or vision insurance with which we participate:

- **We will file claims to your primary and secondary medical insurance, or vision insurance for you, provided we have all current insurance billing information. We will only submit claims to the insurance that you present to us at the time of your visit. The decision to bill medical or vision insurance depends on the specific reason for your visit. At check out the receptionist will clarify how we will bill your visit, and we will not re-bill to a different insurance company later.**
- We expect any required copayment **at the time of service**.
- You are responsible for charges not covered by your insurance carrier.

Our receptionist can clarify whether or not we participate with your insurance plan.

If we do not participate with your insurance:

- Filing your claims is your responsibility. Payment for medical services is due and payable at the time of service**. If surgery is necessary, we will file your insurance claim as a courtesy to you.**

Accounts 90 days past due are subject to collection proceedings, except when prior arrangements have been made with our business office.

Life Time Authorization:

I have read and accept the terms of the Summit Eye Center, P.C.(dba Kirk Eye Center) financial policy.

Authorization Period: From:____________________ To: ____________________* or until revoked/rescinded.

I request the payment of Medicare/private insurance benefits be made either to me or to the provider named above, on my behalf to Summit Eye Center, P.C. for any services rendered by Dr. John D. Kirk and/or associates. I also authorize Summit Eye Center, P.C. to release any protected health information necessary to process my insurance claims, inform other physicians involved in my treatment; or inform my employer regarding work-related injuries. I further permit a copy of this authorization to be used in place of the original.

DATE:______________________ SIGNATURE:____

Please return this form to the receptionist. It will be placed in your file. If you would like a copy, please ask the receptionist to make a copy for you.