Kirk Eye Center

See all that you can

Kirk Eye Center
3650 E 15th St
Loveland CO 80538

Financial Policy

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, including co-pays, co-insurance and outstanding deductibles. We accept cash, personal checks, and most major credit cards for payment of your account.

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.

Plans we participate with: Kirk Eye Center will file claims to your primary, secondary or vision insurance for you, provided we have all current information at the time of service, and will NOT re-bill insurance that was not provided at the time of service. The decision to bill medical or vision insurance depends on the specific reason for your visit. At checkout, the receptionist will clarify how we will bill your visit.

Plans we DO NOT participate with: You will be responsible to pay at the time of service. We will provide a copy of your claims for your records to file on your own.
Charges not covered by your insurance plan will be your responsibility and due at the time of service.

Collections:
If payments are not made on my account within 60 days, the account will be turned over to an outside collection agency, and a **$50.00** collection fee will be added to your account. You and your families care will be suspended until paid in full with the collection agency.
Returned Check: If a check is returned for Non-Sufficient Funds, a $25.00 fee will added to your account, and will be expected to pay in full within 10 days of receiving a letter, or collection procedures will take place.

By providing us with your landline or cell phone number, you give express authorization to contact you at those numbers. This express authorization also applies to any landline or cell phone number you may acquire in the future. Phone calls to you may be made utilizing automated dialer technology.

Missed Appointments:
I understand that if I do not show up for a scheduled appointment, I will receive a warning. If there is a second missed appointment, you will be charged $35.00

I have read and accept the terms of the Summit Eye Center, P.C.(dba Kirk Eye Center) financial policy, and agree that the terms of this policy are in effect from the date signed on this policy.

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.

SIGNATURE: **DATE:**