Kirk Eye Center

See all that you can

Financial Policy

At Kirk Eye Center, our financial policies are designed to ensure the continued availability of quality medical care to all our patients. We are committed to working with you to help ensure that financial matters do not interfere with your access to necessary care.

Payment Responsibility

Payment for medical services, including co-pays, co-insurance, and unmet deductibles, is ***due at the time of service***. We accept cash, personal checks, CareCredit, and most major credit cards.

Insurance Information

Your health insurance policy is a contract between you and your insurance company. While we are happy to file claims on your behalf when applicable, please understand that **you are ultimately responsible for all charges incurred**.

Insurance Plans We Accept

We will file claims to your primary, secondary, or vision insurance, provided current and accurate insurance information is presented at the time of service. We do not re-file claims for insurance not provided at check-in. Whether your visit is billed to medical or vision insurance will be determined based on the reason for your visit and clarified at checkout. Any services not covered by your insurance plan are your responsibility and payment is due at the time of service.

Insurance Plans We Do Not Accept

For insurance plans we are not contracted with, full payment is due at the time of service. We will provide a detailed receipt so you may file for reimbursement directly with your insurer.

Collections Policy

If your account balance remains unpaid for more than 60 days, it may be referred to a collection agency. A $50.00 collection fee will be added, and care for you and your family may be suspended until the balance is paid in full.

Returned Checks

A fee of $25.00 will be charged for any check returned due to insufficient funds. This fee and the original balance must be paid in full within 10 days of notification to avoid further collection action.

Communication Consent

By providing us with your landline or cell phone number, you authorize us to contact you at those numbers. This includes calls made using automated dialing systems or prerecorded messages, and applies to any future phone numbers you may provide.

Missed Appointments

We require at least 24 hours' notice for appointment cancellations. A **$50.00 fee** will be assessed for missed appointments without proper notice.

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 physician 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:_____