W. David Rummel, M.D.
R. Mark Rummel, M.D., Ph.D.
John H. Rummel, M.D.
James B. Arthur, M.D.
Robert W. Preston, M.D.

Diplomats of the American
Board of Ophthalmology

Diplomats of the American
Board of Quality Assurance &
Utilization Review Physicians

Steven M. Meyers, O.D.
Doctor of Optometry

Amy H. Champ, O.D.
Doctor of Optometry

Rummel Eye Care…
Committed to providing
uncompromised quality care.

1022 Willow Creek Rd. #200
Prescott, AZ 86301
928-445-1341

2517 Great Western Dr., Ste I
Prescott Valley, AZ 86314
928-775-4066

# Rummel Eye Care, P.C.

Effective October 1, 2011

Thank you for choosing Rummel Eye Care, P.C. for your eye care needs. Please carefully read and initial by each statement and sign below. This policy has been put in place to ensure that financial payments due are recovered to allow us to continue to provide quality medical care for our patients. It is important that we work together to assure that payments for services is as simple and straightforward as possible.

1. __________ I understand that if I do not have my insurance card, referral, and/or co-payment, that my appointment may be rescheduled until such time that I can provide the required documents or payments.

2. __________ I understand that prior to any surgery or procedure, Rummel Eye Care, P.C. will collect co-payments, deductibles, and/or co-insurance in any amount based on your insurance coverage or lack of coverage for the planned surgical procedure. Any deductible or coinsurance payment amount, up to an amount equal to payment in full, is determined by the anticipated billing code(s), details of your insurance policy, and agreement between your insurance company and Rummel Eye Care, P.C.

3. __________ I understand if my account is not paid in full within 30 days of the first statement a finance charge of $5 will be added to my balance. If my account is not paid in full within 90 days, a $25 collection-processing fee will be added to the outstanding balance and will be turned over to a collection agency for further processing. No additional appointments will be made for delinquent accounts until they are brought current.

4. __________ I understand that a $25 service fee will be added for any NSF checks and I will be responsible for payment of this fee and the amount of the returned check. NSF checks must be redeemed with cash, money order, or cashier's check.

5. __________ Rummel Eye Care, P.C. will allow 60 days from the date of filling for my insurance company to process or pay a claim. Arizona law allows insurance companies in the state no more than 30 days to process claims. It is my responsibility to provide my insurance company with the requested information needed to process claims for services. It is also my responsibility to notify Rummel Eye Care, P.C. if there is a change in my insurance coverage. I further understand that it is up to me to know my insurance benefits.

6. __________ I understand that there may be fees associated with medical records requests and completion of forms by a physician. I understand that I may be responsible for these fees.

7. __________ **I have read and understand the above Financial Policy and I agree to abide by its terms.**

| | |
|---|---|
| Signature | Relationship |
| Printed Name | Date |