



EMPIRE EYE
PHYSICIANS

EmpireEye.com

COEUR D'ALENE OFFICE

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SPOKANE VALLEY OFFICE

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Acknowledgement of Financial Policy

Welcome to Empire Eye Physicians. It is the policy of Empire Eye Physicians that payment is due at the time of service unless other financial arrangements are made in advance. All patients are required to pay his or her copay payment and co-insurance at the beginning of each visit and at the conclusion of each visit any outstanding balances. Empire Eye Physicians, as a courtesy, typically verifies patient benefits with insurance companies. If the patient is covered by health insurance benefits, insurance will be billed. Any unpaid balances after insurance payment is the patients' responsibility.

Account Responsibility: The patient or their authorized party is responsible for all charges incurred on the account. It is the patient's responsibility to ensure the required personal information is current and accurate as well as to understand what his or her insurance benefits cover. Accepting insurance does not place the financial responsibility onto the practice and the patient will be held accountable for any unpaid balance. Although Empire Eye Physicians is contracted with most insurance carriers, some ophthalmology services may not be covered by an insurance plan.

Payment Terms: Balances are due in full within 30 days of receiving a statement. Delinquent accounts will be turned over to collections.

Self-Pay/ No Insurance/ Elective Procedures: If a patient has no insurance or is having an elective procedure, payment in full is expected at the time of service unless arrangements have been made prior to the visit.

Payment Methods: Acceptable payment methods include cash, checks, Visa, Discover Card, Master Card or American Express. A \$35 service charge will be assessed on all insufficient fund checks. Office visits and procedures performed in clinic and/ or surgery center are covered separately and may be credited towards a deductible.

I have read and understand each of the above items.

Patient Name (Print)

Patient Signature

Date