Mark C. McGannon, MD

Michael J. McMullen, MD

Orangeburg Eye Center, LLC

1190 Summers Ave.

Orangeburg, SC 29115

Daoling Zhang, MD

James Van Hulle, MD

FINANCIAL POLICY

Revised March 2020

CLAIMS AUTHORIZATION: I understand the services provided today for this patient may or may not be covered by my health plan. If my health plan deems these services are non-covered or not medically necessary, then I understand that I am financially responsible for any non-covered or non-medically necessary services and/or supplies provided. Such non-covered services may include a refraction fee ($30.00) which is not covered by many insurance plans. I request that payment of authorized Medicare, Blue Cross/Blue Shield, Medicaid or Private Insurance benefits be made directly to Orangeburg Eye Center for any services rendered to me by the physicians associated with Orangeburg Eye Center. I authorize any holder of medical information about this patient be released to the Health Care Financing Administration and its agents, DSS, or private insurance carrier to determine benefits payable for services rendered.

This authorization shall become effective immediately upon execution and shall remain in effect for the duration of any claim or term of insurance coverage including a reasonable time thereafter, until its final consummation.

I understand that I am financially responsible for all charges including deductibles, co-pays, co-insurance and non-covered services, not paid by the specified insurance at the time services are rendered. I further understand that I am financially responsible for all attorney fees or legal fees required to collect any balance due by me. I further understand that my account may be turned over to a collection agency or other outside sources in order to collect any balance owed by me due to nonpayment. I permit a photocopy of this authorization as valid as the original.

MINORS: I understand that by signing this document, providing my picture ID and social security number: I am accepting responsibility for this minor child's medical expenses including contact lenses or glasses. This will remain in effect until I can show legal documentation which states that I am no longer financially responsible for this child's medical expenses.

FAILURE TO MAKE PAYMENTS POLICY: I understand that I am financially responsible for all services rendered, whether covered by my insurance plan or not. I will be billed for any payments that are non-covered. This may include a refraction fee ($30.00) which is not covered by many insurance plans including Medicare. In addition, I understand that I may not purchase or order contacts if I have an outstanding balance or if I have not picked up or paid for previously ordered contacts.

RETURNED CHECK FEE POLICY: I understand that I will be charge a service charge for all returned checks written for payment on my account. I further understand that in the event I present a non-valid check, it is my responsibility to make a valid form of payment immediately, including the service charge.

I VERIFY I HAVE READ AND AGREE TO THE ABOVE AUTHORIZATION.

PATIENT:______________________________

LEGAL GUARDIAN NAME PRINTED:______________________________

LEGAL GUARDIAN SIGNATURE:______________________________

DATE:______________________________