Gupta Eye Center LLC
310 S County Farm Rd.
Suite B
Wheaton, IL 60187

Financial Policy

Thank you for choosing Gupta Eye Center as your ophthalmology provider. We are committed to providing you with the best care possible. This is provided to you to ensure that you understand our policies regarding payments for our services.

Health Insurance: Our office participates with several insurance plans. We do not accept vision coverage plans. It is your responsibility to bring your insurance card to every visit and make us aware of any changes in coverage. It is your responsibility to obtain a referral form your primary care doctor if required. If you do not have your referral, your appointment may be rescheduled or you may be financially responsible. Please be aware that that some services may not be covered by your insurance company. You will be responsible for these payments at the time of your visit. We recommend that you contact your health insurance provider to verify your coverage and understand your benefit plan. Failure to provide complete insurance information may result in patient responsibility for the entire bill.

Note: If our physicians do not participate in your insurance plan or you do not have insurance, payment is expected in full at the time of your visit. For scheduled appointments, prior balances must be paid before your visit.

Deductibles, Co-Pays, and Coinsurance: All co-pays are due in full at the time of service as required by your health insurance company. You are responsible for any deductibles and coinsurances. We accept cash, check, and debit and credit cards (Visa, Mastercard, Discover, and American Express). Postdated checks will not be accepted.

Note: We are considered a specialist and your co-pay may be more than your regular co-pay.

Past Due Accounts: If you have an outstanding balance, our office will attempt to make payment arrangements with you. We will call the number on file twice to arrange payment. If we are unable to reach you or cannot come to a resolution, the account may be sent to a collection agency, attorney, and may lead to discharge from the practice. Any fees that we must pay to secure past due balances will be added to your account. Accounts not paid within 30 days will be subject to a 1% monthly finance charge. If your account is submitted to an outside collection agency, you give your permission to release the necessary information to this agency and you acknowledge that you are aware this information ay become a matter of public record.

Cancellation/No-Show Policy: We require a 24-hour cancellation notice. If you fail to show or do not notify us of the cancellation 24 hours in advance, we reserve the right to charge $50.00 for each missed appointment. Unforeseen situations will be taken into consideration such as illness, weather, and car trouble.

Returned Checks: A $40.00 fee plus any bank fees will be charged for each check returned to us unpaid by your bank.

Release of Information: By signing this form, you agree to Gupta Eye Center LLC releasing required medical records to government agencies, insurance carriers, and others to substantiate claims.

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Billing Information: We will make every effort possible to promptly submit claims to your insurance company and provide you with financial statements. It is essential that you provide us with complete and accurate information to submit billing to your insurance company. If a statement is returned to our office due to incorrect information (such as an address or phone number), you may be referred to a collection agency and/or discharged from the practice. To avoid this, please keep your information up to date.

Workers' Compensation and Automobile Accidents: In these cases, you must obtain the claim number, phone number, contact person, and name and address of the insurance carrier prior to your visit. If this information is not provided, you will be asked to reschedule or pay for your visit at the time of service.

Other: There is a fee to reproduce medical records and complete forms (i.e. disability forms). These fees are based on annual guidelines from the federal government and Illinois. These are your responsibility, not your insurance. There is no fee for medical records sent to another healthcare provider's office.

Questions regarding financial arrangements should be brought to our attention at 630-407-1300.

Please sign this form below to acknowledge that you have reviewed our Financial Policy.

I have read this Financial Policy and agree to the terms and conditions outlined in this policy. I hereby consent to medical care and treatment deemed necessary and proper by my ophthalmologist. I understand that I am responsible for any costs not covered by my health insurance.

_____ _____
Patient Signature Parent/Guardian Signature

_____ _____
Patient Name (Please Print) Parent/Guardian Name (Please Print)

_____ _____
Patient Date of Birth Relationship to Patient

_____
Date