



**RICHARD M. KOOTMAN, M.D., P.C.**  
Board certified Eye Physician and Surgeon  
Specializing in Corneal and Cataract Surgery  
Lasik Laser Vision Correction

**TARA MILLER, O.D.**  
Optometrist

PATIENT FINANCIAL POLICY

We are committed to providing the best possible medical care and patient experience to our patients. Patients knowing and understanding their financial responsibility is a key component to a positive care experience and a successful physician patient relationship.

**Non-covered services:** Patients are responsible for knowing their insurance coverage and bringing their insurance cards to their appointments. Please know your insurance benefits before each visit. You will be asked to pay for any services that are not covered by your insurance plan.

**Correct Insurance Information:** You are responsible for providing us with the most correct and updated information about your health insurance. It is your responsibility to notify us immediately of a change to your health insurance plan or a change in insurance status. If we have incorrect insurance information, outstanding balances will be billed directly to you.

**Payment is Required at the Time of Service:** You are responsible for paying deductibles, co-payments, coinsurance and other out-of-pocket expenses at the time of service. If we are unable to verify your insurance coverage, you will be asked for payment. In addition to cash payments and checks we accept most major credit cards. Patients who are not covered by health insurance are required to pay for the provided services at the time of service.

**Missed Appointments:** Multiple missed or no show appointments will result in a \$25 charge per occurrence and the patient may be subject to discharge.

**Special Insurance processing requests:** The Arizona State Constitution permits insured individuals to pay directly for health care services, if they so desire. If you choose to pay directly for health care services, your health care provider will not submit a claim to your health plan. It is your responsibility for notifying your provider's office when you do not wish a claim to be submitted on your behalf.

**Related Facilities:** Arrowhead Eye Center Doctors may have a financial interest in where you are referred for treatment. This may include, but are not limited to, Spectra Eye Institute and other medical and non-medical related entities.

**Collection Agency Fees:** When patient accounts become extremely delinquent, patients or patients guarantors agree to pay collection agency or attorney fees of not less than 35 percent. The collection agency fees will be added to the patient's outstanding balance and collected by the collection agency upon referral to the agency.

**Administrative Charges:** Patients may incur, and are responsible for, the payment of additional charges at the discretion of AEC. These charges may include but are not limited to (subject to change at any time):

- Charge for returned checks. \$25.00
- Charge for extensive phone consultations and /or after-hours phone calls requiring diagnosis, treatment, or prescriptions. \$100.00
- Charge for copying and distribution of patients medical records. \$35.00
- Charge for forms completion, including but not limited to disability and FMLA forms. \$35.00

**Patient Authorizations**

- By my signature below, I hereby authorize AEC and the physicians, staff, labs and hospitals associated with AEC to release ALL medical and other information acquired in the course of my examination and /or treatment to the necessary insurance companies, third party payors, and/or other physicians or healthcare, and/or other physicians or healthcare entities required to participate in my care.

I have read, understand, and agree to the provisions of this Policy:

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Printed Name of Guardian (if applicable)

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date

**Waiver of Patient Authorization**

I do not wish to have information released and prefer to pay at the time of service and/or to be fully responsible for payment of charges and to submit claims to insurance at my discretion.

\_\_\_\_\_  
Signature of Patient or Guardian

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