McMinnville Family Eye Care, LLC
2185 NW 2nd Street, Suite A
McMinnville, OR 97128
(503) 435-1231

Payment Policy

At McMinnville Family Eye Care we believe that our primary goal and responsibility is to help our patients achieve and maintain excellent health. We would like to spend a moment at the beginning of our physician-patient relationship to explain out office payment policy. It is our hope that by doing so, misunderstanding, frustration and wasted time at a later date can be avoided for all concerned.

•All accounts are due and payable in full at the time of service unless prior arrangements have been made with our office manager or our clinic is a member of your insurance plan. In this latter case, a co-payment or percentage of the amount for that day's visit may be due depending upon the features of your insurance policy.

•We accept debit and credit cards of all types. There is a $20 charge for all returned checks. After 90 days without payment, your account is considered delinquent and will be sent to collections. All accounts assigned to collections will be charged a $35 collection fee.

•Primary insurance companies with whom we have a contract are gladly billed as a courtesy to our patients when complete billing information is provided. ULTIMATELY, YOU ARE RESPONSIBLE FOR PAYMENT OF YOUR ACCOUNT. We cannot accept responsibility for collecting an insurance payment after 60 days or for negotiating a disputed claim. You will receive a statement for us for any balance due after your insurance company has made payment. This balance is due upon receipt.

•There will be a $50 minimum fee for any appointment not kept or not canceled with 24-hours notice. Missed appointments and those canceled with short notice increase both the appointment waiting time for other patients and the cost of medical care for all of us.

I HAVE READ THE ABOUT PAYMENT POLICY AND UNDERSTAND THAT REGARDLESS OF MY INSURANCE COVERAGE, I AM RESPONSIBLE FOR PAYMENT OF MY ACCOUNT. FURTHER, I UNDERSTAND THAT DELIQUENT ACCOUNTS WILL BE ASSIGNED TO A CREDIT REPORTING COLLECTION SERVICE. IF IT BECOMES NECESSARY TO RESORT TO COLLECTION ACTION FOR ANY BALANCE OWING ON THIS OF SUBSEQUENT VISITS, THE UNDESIGNED AGREES TO PAY FOR ALL COSTS AND EXPENSES.

SIGNATURE:______________________________________ DATE:_______________