

**DR. JAY MULANEY
CENTRAL FLORIDA EYE ASSOCIATES
814 GRIFFIN RD., LAKELAND, FL 33805**

FINANCIAL POLICY FOR PATIENT CARE SERVICES

Thank you for choosing Central Florida Eye Associates. Our goal is to provide our patients with the highest quality care of their eyes. To help ensure this we have established the financial policy below. You can assist us in keeping costs down by ensuring we are reimbursed for services in a timely manner.

1. If you have health insurance, provide us with complete and accurate information. It is our policy to file your insurance as a courtesy to you. (ALWAYS BE SURE WE HAVE THE MOST CURRENT UPDATED INFORMATION ABOUT YOU AND YOUR INSURANCE COMPANY).
2. Please pay any co-pays and annual deductibles prior to being seen ON THE DATE OF SERVICE. When we receive payment from your insurance company, we will bill you for any remaining accounts.
3. Please assist us in contacting your insurance company when payment is not made within a reasonable time. If the insurance company does not make payment within 45 days, we may hold you responsible for the full amount.
4. If you do not have insurance, or our doctor is not a provider for your insurance, you will be expected to pay at the time of service. Financial arrangements can be made through the office manager only.

Patients undergoing eye surgery will have separate charges payable to **Central Florida Eye Associates** for 1) surgery and 2) pre-operative testing. We request that your portion of these fees be paid prior to your date of surgery. That will include all annual deductibles, co-pays, and percentage amounts. Please contact the office manager with any questions concerning financial arrangements. In addition, there is a facility fee for the use of the operating room and nurses during the day of surgery. This is to be paid to **Lakeland Surgical and Diagnostic Center**.

I hereby acknowledge that I have read and understand the financial policy of Central Florida Eye Associates and agree to comply with all aspects of the policy that pertain to me.

Signed _____

Date _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I have read a copy of Central Florida Eye Associates' Notice of Privacy Practices. I can direct any questions to the privacy officer at (863) 686-1010.

Signed _____

Print Name of Patient _____

Date _____