Eye Care Of Illinois LTD.

Treatment Of Ocular Disease and Visual Disorders

Dr. Craig A. Sieron O.D.
Dr. Ernest C. Doiron O.D.

PAYMENT POLICY

Any and all fees are due at the time of service. All contact lenses must be paid in full before ordered. Any co-payments are due at the time of service.

If you have insurance coverage for these services or materials, we will submit claims for you. However, we are not liable for collecting your claim. After thirty days, we will expect payment in full if your insurance company has not paid.

Returned NSF checks will be charged a service fee of $25.00.

I HERE BY AUTHORIZE MY INSURANCE CARRIER TO MAKE PAYMENT DIRECTLY TO EYE CARE OF ILLINOIS FOR ANY AND ALL SERVICES RENDERED TO ME BY EYECARE OF ILLINOIS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT COVERED BY INSURANCE.

I also release any information regarding my treatment or condition in order to obtain payment for professional services.

I HAVE READ AND AGREE TO THE PAYMENT POLICY STATED ABOVE.

Signature ______________________________ Date ____________