

Dr. Dirk Beyer
OPTOMETRIST



820 W Main • P.O. Box 2068
Hamilton, MT 59840
(406) 363-2020
Fax (406) 363-0646

Big Sky Eye Care Financial Policy

Dr. Beyer and staff are pleased that you have chosen us for your eye care needs. We would like to make you aware of our financial policy and appreciate your cooperation. Please review the policy and sign below.

EXAMINATION/TREATMENT - Payment in full is due at the time of service.

PRODUCTS (contacts, glasses, etc.) - Payment for products require 50% down upon ordering and the remaining balance is due upon receipt of the product.

BILLING INSURANCE - We gladly bill your insurance, but you are ultimately responsible for all charges not paid for by your insurance company.

CO-PAYMENT - The patient share of the bill is due at the time of service.

HOW WILL YOU SETTLE ON YOUR ACCOUNT TODAY?

We accept: CASH CHECK MASTERCARD VISA DISCOVER AMEX CARE CREDIT
(If Insurance, Complete reverse side of form)

I acknowledge that I am responsible to pay for all charges for treatment/services administered by Big Sky Eye Care. I understand and agree to the above terms of payment. I understand that if I fail to make my payments, my account may be turned over to a collection agency. I understand and agree to pay reasonable attorney and/or collection fees accrued should my account become delinquent.

Signature _____ Date _____

Print Name _____

Please complete reverse side of form

Dr. Dirk Beyer
OPTOMETRIST



820 W Main • P.O. Box 2068
Hamilton, MT 59840
(406) 363-2020
Fax (406) 363-0646

Big Sky Eye Care Financial Policy

Dr. Beyer and staff are pleased that you have chosen us for your eye care needs. We would like to make you aware of our financial policy and appreciate your cooperation. Please review the policy and sign below.

EXAMINATION/TREATMENT - Payment in full is due at the time of service.

PRODUCTS (contacts, glasses, etc.) - Payment for products require 50% down upon ordering and the remaining balance is due upon receipt of the product.

BILLING INSURANCE - We gladly bill your insurance, but you are ultimately responsible for all charges not paid for by your insurance company.

CO-PAYMENT - The patient share of the bill is due at the time of service.

HOW WILL YOU SETTLE ON YOUR ACCOUNT TODAY?

We accept: CASH CHECK MASTERCARD VISA DISCOVER AMEX CARE CREDIT
(If Insurance, Complete reverse side of form)

I acknowledge that I am responsible to pay for all charges for treatment/services administered by Big Sky Eye Care. I understand and agree to the above terms of payment. I understand that if I fail to make my payments, my account may be turned over to a collection agency. I understand and agree to pay reasonable attorney and/or collection fees accrued should my account become delinquent.

Signature _____ Date _____

Print Name _____

Please complete reverse side of form

Medical / Vision Insurance Information

Patient Name _____ DOB: _____

Medical Insurance Company _____
(Ex: BCBS, Aetna, EBMS)

Insured's Name _____ DOB _____
(if different from patient)

Policy# _____ Effective Date _____
Insured's SSN# _____

Vision Insurance Company _____
(if different from Medical Insurance, Ex: VSP, Eye Med, Mountain Vision)

Insured's Name _____ DOB _____
(if different from patient)

Policy# _____ Effective Date _____
Insured's SSN# _____

Do you participate in a Flexible Spending Program? YES NO

<-----OFFICE USE – Copy Insurance Card below / front & back ----->

Medical / Vision Insurance Information

Patient Name _____ DOB: _____

Medical Insurance Company _____
(Ex: BCBS, Aetna, EBMS)

Insured's Name _____ DOB _____
(if different from patient)

Policy# _____ Effective Date _____
Insured's SSN# _____

Vision Insurance Company _____
(if different from Medical Insurance, Ex: VSP, Eye Med, Mountain Vision)

Insured's Name _____ DOB _____
(if different from patient)

Policy# _____ Effective Date _____
Insured's SSN# _____

Do you participate in a Flexible Spending Program? YES NO

<-----OFFICE USE – Copy Insurance Card below / front & back ----->