Darrell E. Genstler, MD
Refractive Cataract Surgery
Acute EyeCare
Eye Trauma
Glaucoma
Dry Eye

Benjamin M Jäger, OD
Primary Vision Care
Acute EyeCare
Glaucoma
Contact Lenses

Kent D Reynolds, OD
Primary Vision Care
Acute EyeCare
Glaucoma
Contact Lenses

Tad Abernathy
Practice Administrator

Gina Steele
Assistant Administrator

Genstler Eye Center
2700 14th Ave. SE
Albany, OR 97322
(541) 928-1667
(800)338-2009

EyeWear Pavilion
(541) 926-1618
Opticians
Bob Coe, ABOC
Rhonda Smith, ABOC
Brooke

Eye Surgery Center
(541) 928-1667
Nursing Director
Connie Arnold, RN

Genstler Hearing Center
(541) 926-1667
Nick Schenfeld
Hearing Aid specialist

Web Site: letsee.com

FINANCIAL POLICY

GENSTLER EYE CENTER

METHOD OF PAYMENT: You can choose to pay by cash, check, credit card, or money order.

PAYMENT: All charges are due at the time of service unless other arrangements are made in advance. Any co-payments required by an insurance company must be paid at the time of service.

MONTHLY STATEMENT: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the service fee (if any) and payments or credits applied to your account during the month. Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and **is past due if not paid within thirty (30) days**.

INSURANCE: Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance company for 60 days as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. **If your insurance company requires a referral and/or pre-authorization, you are responsible for obtaining it and presenting it at the time of service. If you do not bring a referral, you will be expected to pay at the time of service**.

ADMIN FEE: **An Admin Fee of $20 will be imposed for any co-pays or out-of-pocket tests not paid within 24 hours of the visit**.

MISSED APPOINTMENT FEE: If you are unable to keep your appointment, or cancel with less than 24 hours notice, we are unable to offer this appointment to other patients. **Therefore, we currently charge $50.00 for a missed appointment**.

PAST DUE ACCOUNTS: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer your account to a lawyer, you agree to pay all lawyers' fees which we incur plus all court costs.

DIVORCE: In case of divorce or separation, the party responsible for the account prior to the divorce or separationremains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

TRANSFERRING OF RECORDS: You will need to request in writing, and pay a reasonable copying fee, if you want to have copies of your records sent to another doctor or organization. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

WORKERS COMPENSATION: We require written/verbal authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

PERSONAL INJURY: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility.

RETURNED CHECKS: **There is a $25 fee for any checks returned by the bank**.

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Signature of Patient/Credit Card Holder Today's Date Print Name of Card Holder

For Office Use Only: Genstler Eye Center Account #_____