TOWER CLOCK
EYE CENTER
The difference is in sight.

TYSON SCHWIESOW, M.D.
KURT SCHWIESOW, M.D.
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FINANCIAL POLICIES

PAYMENT POLICY: You are financially responsible for the services provided through Tower Clock Eye Center. Statements are sent after insurances have responded or after 45 days if your insurance has not responded to your claim. Your payment is due within 21 days from the statement date. Contact our business office if a payment plan is needed.

REFRACTIONS: Refractions are considered routine by Medicare and most insurances and are not covered. Refractions are a separate charge and will be submitted to your health insurance carrier.

INSURANCE CARDS AND DRIVERS LICENSE OR PHOTO ID must be presented for copying at the time of each service. Insurance coverage represents a contract between you and your insurance carrier and is not a guarantee of payment. If incorrect insurance information is provided (wrong carrier, ID numbers, effective date or primary carrier) and a second filing is needed, a re-filing fee will be charged.

Our physicians are on contract with most insurances and Medicare and Medicare Advantage plans; you are responsible for deductibles, co-pays and non-covered services.

Co-pays are due at the time of service.

Injury and Accident Claims: In addition to required information to submit these claims. Personal health insurance and photo ID are required. If you seek reimbursement through legal action, you are responsible for the payment of services rendered.

Uninsured patients need to make a payment of **$200.00** at the initial visit. A payment plan must be established with the business office before leaving.

Returned checks: A returned check fee will be added to the account.

Collection Agency Account Placement: A fee of **30%** of the amount placed with the collection agency will be added to the account. In the event legal action through the collection agency is warranted, you will be responsible for any and all fees associated with the court cost, garnishments, and/or attorney fees.

Contact our business office with any questions or concerns.

Signing this agreement, I accept the Financial Policies of Tower Clock Eye Center. I authorize Tower Clock Eye Center to release any information acquired in the course of my examination or treatments to my insurance company, other health care provider, or agencies legally entitled to the information under Wisconsin or Federal statute in order to facilitate payment of the service. I assign payment of authorized benefits directly to Tower Clock Eye Center, SC. This agreement will remain in effect until revoked by me in writing.
A photocopy of this agreement is considered to be valid as the original.

Signature of Patient (parent/guardian if under 18 or POA) _____

Print Name _____ Date _____