D.L. THANEPOHN, OD.
P.N. REBER, O.D.
S.A. LENTFER, O.D.
J.C. FALCONER JR., O.D.
L.M. NOLIN, O.D.
I.P. FORD, O.D.
J.J. COOK, O.D.

Alaska
EYE CARE CENTERS, APC

DOWNTOWN ANCHORAGE
(907) 272-2557

WASILLA
(907) 376-5266

1345 West 9th Avenue
Anchorage, Alaska 99501
(907) 272-2557
FAX (907) 274-4932

Patient Notice of Billing Practices

Vision/Medical Services provided by Alaska Eye Care Centers, APC are payable at the time of service. We accept the following:

Cash, Credit Cards, Personal Checks, Money Orders, and Debit Cards

Payment plan options are offered for large patient balances. (Please ask someone in billing for additional information.) Co-payment and amount due for non-covered services (including deductible) will be expected at the time of service. We will not bill discounted services to insurance unless it's an advertised special. (This does not apply to VSP or Davis Vision members.)

Private Insurance
We compliment our services with insurance claims submission. In many cases we are a Preferred Provider. Most private policies are billed as a courtesy to our patients. We allow a 30-day grace period for your insurance to respond to our claims. If the insurance does not respond to our claims within 30 days, the balance becomes due in full. If you have two insurances, we allow 30 days for the primary insurance payment and 30 days for the secondary insurance payment. If payment is not received from your insurance companies, the full balance is requested from the patient.

Medicare/Medicaid
We are currently accepting both Medicare and Medicaid. If you have either insurance and there is a co-payment required, it will be collected when services are rendered. Please understand that we are required to collect *at time of service*. Applicable waivers will be provided for signatures at appointment.

Tricare
As of January 1st, 2010 we no longer accept Tricare. We are happy to continue our relationship with our Tricare patients but will need to obtain payment in full when services are rendered.

Refund Policy
For any refund owed to patient after insurances have paid we do so in the same manner as payment is received. If you wish for us to automatically refund your credit card please provide us with the information below. We are currently not keeping information on file, unless permission below is granted. No charges for balances will be added without permission from patient. If payment is made by cash or check, Alaska Eye Care Centers, APC will refund by check in the mail directly to patient or guardian. Our Accountant does refunds at the beginning of the month.

Type: Visa Mastercard Discover American Express

Card Number: _____ ***CIC Code:*** _____ ***Expiration Date:*** _____

Name on Card: _____ ***Billing Zip Code:*** _____

I have read the above payment options and understand my financial responsibility to this organization. If you have additional questions, please ask to speak to a billing representative, prior to your appointment.

_____
Patient Name (Printed)

_____ _____
Patient or Guardian Signature Date Signed