Cash Payment Policy
General Insurance Payment Policy

The goal of the Oklahoma Medical Eye Group is to provide out patients with exceptional care. For us to maintain this high standard of care, we respectfully request all co-pays, coinsurances, or deductibles, which apply, be paid at the time services are rendered.

Your appointment today may be for an initial consultation; however, the doctor may find it medically necessary to perform additional testing. If you have questions regarding cost, etc. for any additional tests, please ask any of our staff as you or your insurance company will be charged for services rendered. If your insurance company does not pay or denies your claim within 60 days, you are responsible for payment. We will be glad to assist you in determining any benefit information or acquiring any other information needed from your insurance company.

Authorization:

I hereby authorize Oklahoma Medical Eye Group to release all medical information necessary for processing of insurance claims to all insurers or their agents. I also authorize OMEG to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning my health plan benefits and payments. I direct the insurance company or health plan administrator to release this information to OMEG and allow a Xerographic copy of my signature to be used. I understand that these provisions will remain in full effect until otherwise revoked by me.

State law requires that we advise you that the information authorized for release may include records which may indicate the presence of communicable or venereal diseases which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also know as Acquired Immune Deficiency Syndrome (AIDS).

I certify that I have read and understand the above information.

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_____

Patient Signature Date

If I am not the patient, but instead signing on behalf of the patient, I further certify that I am legally authorized to sign on the patient's behalf and to bind the patient to the above terms and conditions. I agree that the patient and I are jointly and severally responsible for complying with the above terms and conditions, including any and all payment obligations.

_____
_____

Representative Signature Date

_____
Relationship of Representative to Patient

918-747-2020