Account # _____ Initials _____

PROFFITT EYE CENTER

711 N. Custer Ave.
Grand Island, NE

# Optional Payment Plan

**PLEASE READ CAREFULLY**

At Proffitt Eye Center, we continually strive to improve patient service and office efficiency. As part of this effort, we'd like you to consider participating in our program that provides an option for those patients who would rather not pay co-pay or deductible amounts that are expected at the time of service. If you choose to participate in this program, just provide our check-in staff with your credit card to scan so that the information can be held securely until after your insurance(s) have paid their portion and notified both you and us how much, if any, is your responsibility. At that time, any remaining balance owed by you will be charged to the credit card that you provided and we'll send you a receipt showing the amount paid. You won't be called before this transaction is processed on your credit card.

The advantages to you include no longer having to write out and mail checks, for which your bank may charge a per-check fee and there's the expense of postage. There are advantages for us as well since it will greatly decrease the number of statements we must generate, which involves staff time and the expense of postage.

You wouldn't want a customer to leave your business without making arrangements for payment, and our policy is no different and similar to how hotels and other businesses take your credit card information for later use to pay your bill. Providing credit card information is not mandatory and in no way compromises your ability to dispute a charge or question your insurance company's determination of payment.

If you'd like an estimate of the expected out-of-pocket expense, we can calculate the amount for which you'll be liable after your insurance carrier has processed our claim, although the amount of deductible you have left to meet may be an unknown factor.

We have other financing programs available including *CareCredit*, which offer 3-month interest-free payment plans for balances over $300. Please let us know if you'd like more information about these options since our office policy requires that arrangements for payment be made prior to services being performed. Please let us know if you have questions or need additional information about this program.

We appreciate your cooperation,

Proffitt Eye Center

---

I authorize Proffitt Eye Center to charge to the following credit card any outstanding patient balance for me and/or my dependents: (please circle one) **CREDIT CARDS ONLY! NO DEBIT CARDS PLEASE**

VISA MasterCard Discover CareCredit

Print full name as it appears on the credit card _____

Signature _____ Date _____

***If you'd like to participate, please present this signed form to our check-in staff along with your credit card for scanning.***