COMPLETE EYE CARE INC.
9890 Clayton Road, Suite 200
Saint Louis, MO 63124
Phone: 314-395-9613 Fax: 314-395-9621

Kevin Greuloch, M.D. Sharon Jick, M.D. Paul Luong O.D.

OFFICE POLICIES AND PROCEDURES

Thank you for choosing Complete Eye Care, Inc. In order to provide you with the best care, we request that if you are going to be late, please call the office to let us know. We cannot always accommodate late arrivals therefore, we may have to reschedule your appointment. If appointments are not cancelled or you no-show your appointment, a $25.00 fee will be assessed to your account. **Please plan for most appointments to last at least 90 minutes.**

Insurance: We participate in many insurance plans including Medicare. **We do not accept Medicaid.** **Knowing your insurance benefits is your responsibility.** Please let our receptionist know whether you are using your medical or routine vision benefit prior to your appointment. If your insurance plan requires you to have a referral, it is your responsibility to obtain the referral from your primary care provider **BEFORE** your appointment. It is the patient's responsibility to inform our office of any change in insurance coverage. Failure to do so could delay or result in a denial of insurance payments. The patient is ultimately responsible for ALL outstanding balances.

Co-Payments and Deductibles: Patients are responsible for all copayments ***at time of service.*** You will be billed for any applicable deductibles or co-insurance amounts and/or fees for service not covered by your insurance (as stated in your insurance contract) by our billing department. If we are unable to verify insurance coverage prior to your scheduled appointment, you will be responsible for fees associated with the office visit ***at time of service***. We accept cash, check and certified check, Visa, MasterCard and Discover as forms of payment. There will be a $25.00 fee for all returned checks.

Thank you for reviewing our policies. Please let us know if you have any questions or concerns.

I have read and understand the above policies and agree to abide by the policies and procedures of Complete Eye Care, Inc.

Signature of patient or responsible party Date