Our Financial Policy

Tom F. Mihok, O.D.
141 California Avenue
Oakdale, Ca 95361
(209) 847-3051
Fax (209) 847-1405

We are committed to providing you with the best possible care. If you have insurance, we will be happy to help you receive your maximum allowable benefits. In order to achieve these goals, we will need your assistance, and your understanding of our payment policy.

Payment is due when services are rendered unless payment or insurance arrangements have been approved in advance by our staff. We accept cash, check, Mastercard, Visa and Discover card as payment. We will be happy to process your insurance claim; however, any insurance claims not paid within 90 days from the date filed will become your responsibility.

You will be charged $25.00 for any check returned for insufficient funds. It will be necessary to bring either cash or money order for full payment of the original charge plus the $25.00 returned check fee within one week notification by our office of the returned check. In addition, any non-insurance account that is 30 days past due will be subject to a $25.00 collection fee and automatically transferred to our collection agency.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1. We will be happy to bill all primary insurances; however, secondary insurances must be the patient's responsibility to bill unless otherwise arranged.
2. Your insurance is a contract between you and your insurance company. We are not party to that contract.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select services they will not cover.

We must emphasize that as health care providers, our relationship is with you, not your insurance company. While filing insurance claims is a courtesy that we extend to our patients, all charges are ultimately your responsibility. If temporary financial problems are affecting timely payment of you account, we encourage you to contact us promptly to work out a payment plan that will work for both of us.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help.

I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL POLICY.

Signature_____ Date _____

Patient Signature on File
Lifetime Authorization

Patient Name _____ Date _____

Insurance ID#/ Social Security # _____ Birthdate _____

I request that payment of authorized insurance benefits (Including Medicare Benefits) for any services furnished to me, be made on my behalf to Tom. F. Mihok, O.D.

Signature _____

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

_____ _____
Relationship to Patient Print Name

Source of Authority: _____

Acknowledgement of Receipt
Notice of Privacy Practices

I acknowledge that I have received a copy of the ***Notice or Privacy Practices*** from Tom F. Mihok, O.D.

Signature _____ Date _____

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

_____ _____
Relationship to Patient Print Name

Source of Authority: _____

Consent for the Treatment of a Minor.
This must be signed for every minor.

I hereby authorize Tom F. Mihok, O.D. to treat the following minor:

Name of Minor _____

Parent/ Guardian _____

Phone Number _____

Signature _____ Date _____
Signature of Parent/ Guardian