

WILSON EYE CARE CENTER, LTD.  
Robin L. Crocker-Wilson, O.D., R.N.  
2000 W. Pioneer Parkway, Suite 23  
Peoria, IL 61615  
Office (309) 690-3336 Fax (309) 690-7820  
E-Mail: info@wilson-eyecare.com

### **PAYMENT POLICY**

Examination fee is due at the time of service. All contact lenses must be paid in full before ordered. Any co-payments are due at the time of service.

If you have insurance coverage for these services or materials, we will submit claims for you. However, we are not liable for collecting your claim. After 30 days, we will expect payment in full if your insurance has not paid.

Returned NSF checks will be charged a service fee of \$25.00.

**I HEREBY AUTHORIZE MY INSURANCE CARRIER TO MAKE PAYMENT DIRECTLY TO WILSON EYE CARE CENTER FOR ANY AND ALL SERVICES RENDERED TO ME BY WILSON EYE CARE CENTER. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT COVERED BY INSURANCE.**

I also release any information regarding my treatment or condition in order to obtain payment for his professional services.

**I HAVE READ AND AGREE TO THE PAYMENT POLICY STATED ABOVE.**

Signature \_\_\_\_\_ Date \_\_\_\_\_