Financial Policy

Thank you for choosing our office as your family's eye care provider. We are committed to providing you with the highest quality eye care. Please understand that payment of your bill is considered part of your eye care. Payment for services is needed at the time of your visit, unless prior arrangements have been made. **Payment in full is due to order your custom glasses or contact lenses**. Our office accepts cash, personal checks, Care Credit, MasterCard, Visa, American Express and Discover.
Please Note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance; you will be responsible for any collection and/or legal charges incurred to our office up to 33.3%. Statements are mailed monthly. Additional statements mailed after the second statement will incur a $5.00 service fee per statement.

Do you have insurance?

As a courtesy, we will be happy to file your insurance claim and accept assignment of insurance benefits for up to two insurance companies that we are participating providers for. Our staff will be happy to assist you in determining your insurance coverage. However, benefits quoted by your insurance company and their authorization for service(s) are not a guarantee of payment.

Although we file insurance claims as courtesy to you, you are still responsible for payment of services and materials you incur regardless of whether your insurance pays on your behalf. Our practice is committed to providing the best treatment for our patients and will make recommendations based on what we believe is the very best treatment for you, regardless of what your insurance deems as usual and customary. We must emphasize that as your eye care provider, our relationship is with you, our patient, not with your insurance company.
Insurance payments are ordinarily received at our office within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days from the time we file your claim, responsibility for payment on any remaining balance will be transferred and billed directly to you. It is your responsibility to follow up with your insurance company for reimbursement. If we receive a payment from your insurance company after your balance has been paid, we will gladly issue you a refund. It is your responsibility to contact your insurance company if a claim is denied, paid at a lower rate than you expected or if it has not been paid within 60 days. We will cooperate fully with the regulations and requests of your insurance company that may assist in your claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim that they have not or will not pay on your behalf.

We thank you for the opportunity to serve your family's eye care needs and welcome any questions you may have concerning your care or our financial policy.

Consent:

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE FINANCIAL POLICY. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY VISION/MEDICAL BENEFITS DIRECTLY TO MY OPTOMETRIST'S OFFICE. I UNDERSTAND THAT RESPONSIBILITY FOR PAYMENT OF SERVICES PROVIDED IN THIS OFFICE FOR MYSELF OR MY DEPENDENTS IS MINE, DUE AND PAYABLE AT THE TIME SERVICES ARE RENDERED UNLESS OTHER FINANCIAL ARRANGEMENT HAVE BEEN MADE. I FURTHER UNDERSTAND THAT A FINANCE, REBILLING, COLLECTION CHARGE OR ATTORNEY FEE MAY BE ADDED TO ANY OVERDUE BALANCES.

X_____ _____
(Parent or Guardian if patient is a minor) Date