Advanced Eyecare Center Financial Policy

We are dedicated to providing the best possible care and service, and regard the understanding of our financial policies as an essential element of care and treatment. To assist you, we present the following financial policy. If you have any questions, please do not hesitate to discuss them with any member of our staff.

INSURANCE COVERAGE:

It is **your** responsibility to provide our office with accurate information for billing you insurance plan properly at the time of service. It is also **your** responsibility to know whether your visit with us is covered by your insurance plan fully, partially, or not at all and whether your plan requires a referral from your primary care physician before your visit. **For example, you may be covered under your primary healthcare plan for additional vision care services under a different carrier. It is your responsibility to know whether you have this separate coverage.** Information of this type is 100% accurate only if you obtain it directly from your health plan, not from our office staff. In the event you do not confirm this information and the insurer refuses full or partial payment, you will be held personally responsible for the cost of the services provided. **INITIAL**_____

ROUTINE AND MEDICAL EYE EXAMS:

Our office participates with certain vision plans for "routine eye exams". A routine eye exam is, by definition, a "regular check-up" for someone with **no eye problems** who just needs glasses or contact lenses. If the doctor detects any medical condition, (dry eyes, floaters, ect) the exam may become a medical eye exam and will be submitted to your medical insurance. If your insurance plan requires a referral, you will need to obtain one for the exam. Due to insurance company regulations, routine and medical exams may not be performed on the same day. If you desire only the routine portion of the exam on your visit, the doctor may ask you to return another day for the medical exam. **Please note that some insurance plans consider a routine eye exam to be a non covered service.** I have read and understand the above routine eye care policy. **INITIAL**_____

SPECTACLE AND CONTACT LENS EXAMS:

Exam for spectacles and contact lenses are separate exams. If you desire both exams on your visit, you will be charged an evaluation fee for the contact lens exam. We will be happy to submit this charge to your insurance company. However, if this charge is determined to be a "non-covered" service, you will be responsible for this charge, payable before receiving any "diagnostic" contact lens. If your vision plan offers any contact lens material benefit, the cost of the exam may be deducted from this benefit**. INITIAL**_____

AMOUNTS DUE FROM THE PATIENTS:

We gladly accept cash, check, and most credit and debit cards. **Insurance copayments are due at the time of service.** If we do not participate with your insurance plan, you are to provide payment in full at the time of service. We will provide you with an itemized statement of services and amounts paid which you may submit to your insurance. The insurance is then responsible for reimbursing you. If using insurance, we will make every effort to collect full and accurate fees specific to your plan. However, if there is a fee that your insurance charges and we did not collect it at the time of order was placed, it must be paid in full before glasses and/or contact lens will be dispensed. **INITIAL**_____

AMOUNTS DETERMINED "NOT COVERED":

In the event a health plan determines a service of ours to be "not covered"; you will be responsible for the complete charge. An important example of this is our charge for checking eyes for changes in eyeglasses prescription and/or contact lens prescriptions. (Procedure is called Refraction) We charge for this service and many insurances, including Medicare, deem this service "not covered". **You may be personally responsible for this charge. If you do not desire refraction, please inform our office staff. INITIAL**_____

PAST DUE BALANCES AND COLLECTIONS:

Any unpaid balance on your account over 60 days will be assesses a $5.00 late fee for each month the balance remains unpaid. If there is an unpaid balance over 90 days the account will be turned over to a debt collection agency. At that time the late fees will be removed. You will then become responsible for any and all collection agency fees up to 50% of the amount placed with the collection agency. In the event we seek legal action for the collection on your account, you will be responsible for any and all fees associated with court costs, garnishments, and/or attorney fees. **INITIAL**_____

I have read and understand the financial policies of Advance Eyecare Center, your Vision Source Solution, and also understand that Advance Eyecare Center reserves the right to change this policy and all fees at any time.

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Signature of Patient or Responsible Party Date