*Patient Financial Policy continued*

***CANCELLATION POLICY:***

If you are unable to keep your appointment, kindly call 24 hours in advance to reschedule. Otherwise, we reserve the right to charge a fee for time reserved of $50.00

***REFRACTIONS:***

A refraction is when the technician or doctor places different lenses in front of your eyes to give the best vision and release a prescription for eyeglasses. (Fee is $90.00) These fees are subject to change without notice.

***MINORS:***

The parent (s) or guardian (s) is responsible for full payment and will receive the billing statements. A signed release to treat may be required for unaccompanied minors.

***EYE SPECS OPTICAL:***

When purchasing eyeglasses from our optical, Eye Specs Optical, the same financial policies apply, as above.

Thank you for understanding our Financial Policy. We appreciate the opportunity to provide our medical services for your medical needs. Your assistance and cooperation will be most appreciated. Should you have any questions or concerns, please contact us.

I have read and agree with the Financial Policy.

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Patient Name (please print)

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Patient/Responsible Party Signature Date

**The Eye Specialists LTD.**

**Patient Financial Policy**

Thank you for choosing The Eye Specialists LTD. as your health care provider. We are committed to your treatment being successful. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please ask if you have any questions about your fees, our policies, or your responsibilities. Carefully review the following information and return changes (i.e. address, name, insurance information, etc.)

***Insurance:***

It is the patient's responsibility to provide the office with current insurance information. We will ask for your insurance card during your first visit to obtain a copy for our records. We may occasionally request a copy later to update your records so please have your insurance card every time you come to the office. If current information is not obtained at the time of service, it will become the patient’s responsibility to pay until current information is provided to the practice.

Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your claims for you. However, we will not become involved in disputes between you and your insurance carrier. This includes, but is not limited to, deductibles, co-payments, non-covered charges and “usual and customary” charges. We will supply information as necessary. **You are ultimately responsible for the timely payment of your account. After 90 days of non-payment by your insurance, the balance due will become your responsibility.**

**I understand that if my insurance denies my claim for any reason, I will be fully responsible for any balance due.**

***Co-Pays:***

Co-payments are due at the time you check in at the front desk PRIOR to being seen by your doctor.

***UN-PAID BALANCES:***

If your insurance company has not paid the balance in full, you will receive a statement notifying you of the amount due. Any overdue balances will be sent to our collection agency and your account will accrue additional charges.

We accept cash, checks, Visa, MasterCard, Discover and Care Credit.

***RETURNED CHECKS:***

The charge for a returned check is $50.00 payable by cash or credit card. This will be applied to your account in addition to the insufficient funds amount. You will be placed on a cash/credit/debit card only basis following any returned check.