EYEDENTITY

EYECARE + EYEWEAR

FINANCIAL POLICY

Thank you for choosing EyeDentity Eyecare + Eyewear for your vision and eye health needs. The goal of our doctors and staff is to provide you with thorough, professional eye care and quality products that exceed our patient's expectations. Your understanding of our financial policy is an essential part of your care. If you have any questions regarding this policy, please feel free to discuss them with our staff.

FULL PAYMENT FOR PROFESSIONAL SERVICES IS DUE AT TIME OF SERVICE. This includes: all co-pays, Medicare refractions, fees for non-insured patients and contact lens evaluation/fitting fees. Acceptable forms of payment include: cash and personal check. For your convenience, we also accept most major credit cards, FSA/HSA benefit cards and Care Credit. A $30 FEE WILL BE CHARGED FOR ALL RETURNED CHECKS.

If services are provided for a minor patient, the parent/guardian accompanying the patient is responsible for full payment. For unaccompanied minors, non-emergency treatment may be denied unless accompanied by a parent or guardian.

In order for us to bill your insurance company, you will need to provide the necessary information prior to your appointment. If you are unable to provide us with this information, you will be considered private/cash pay. As a courtesy to our patients, if you have supplied us with your current vision insurance policy, we will verify your eye exam and hardware benefits prior to your appointment. We will also bill your insurance company on your behalf. In doing this, we will bill and receive payment directly from your insurance company for covered services. We will do all we can to assist you in obtaining your maximum allowable benefits.

Your medical insurance may be billed for services including: the healthy eye portion of your eye exam, medical office visits, emergency eye care, and any specialty medical testing that may be performed during your routine eye exam. If we are billing your medical insurance, understand that you may have co-insurance or deductible fees due after insurance has processed your claim. Also, please be advised that most medical insurances do not cover routine eye exams. If a referral is required by your insurance, it is the responsibility of the patient to obtain authorization prior to your visit. While we are contracted with many insurance companies, not all services are a covered benefit in all contracts. Routine eye-care, specialty testing, procedures and contact lens fitting or evaluation fees may be specifically excluded, making the patient responsible for the charges. Also, benefits may vary if we are out of network. It is ultimately the responsibility of the patient to know your plan benefits.

Your insurance contract is an agreement between you and your insurance carrier. We are not a party to that contract. If your insurance company denies payment, or has not paid your account in full within 60 days, as required by state law, the balance will be automatically transferred to you. For any remaining balance due after your insurance company pays, we will send you a statement. If there is no payment after 30 days, late fees will incur. Please call if you have any questions about your bill.

We prefer payment in full upon ordering glasses or contacts; however, we will allow you to make a 50% deposit to initiate your order, with the remaining balance to be paid in full when the order is dispensed.

Materials including: frames and prescription or non-prescription lenses, contact lenses, accessories and supplements are all NON-REFUNDABLE. Prescription optical materials are customized and fabricated specifically for each individual patient. Once these items are ordered they become the financial responsibility of the patient. If the prescription itself is not to your liking, you may bring the glasses back within 30 days and have the frame and/or prescription adjusted to resolve any issues. Unopened boxes of contact lenses may be eligible for exchange and will be handled on a case by case basis.

We reserve the right to turn any patient over to a collection agency, if it is deemed that the account has been in default of payment. If we turn your account over to a collection agent, you will be responsible for any administration fees, attorney fees, and/or court costs incurred.

Print Responsible Party Name: ____ **Date:** ____________________
(Patient or parent/guardian if patient is a minor)

Signature of Responsible Party: ____

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