Financial Policy

Thank you for choosing us as your eye care provider. We are committed to providing you with quality services and ophthalmic materials. Some of our patients have had questions regarding patient and insurance responsibility. Please read our financial policy, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance**. We participate in many insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions that you may have regarding your coverage.
2. **Co-payments**. All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company.
3. **Non-covered services**. Please be aware that some of the services that you receive may be non-covered by insurers.
4. **Proof of Insurance**. All patients must complete our patient information before seeing the doctor. We must obtain a copy of your current, valid insurance card to provide proof of insurance and allow us to verify your coverage.
5. **Claims submission**. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.
6. **Coverage changes**. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.
7. **Nonpayment**. If your account is over 90 days past due, you will receive a letter encouraging you to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency. No services may be rendered or materials ordered for any members of your household until the unpaid balance is settled.

Our practice is committed to providing the best treatment to our patients. Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

By signing here I understand that I am financially responsible for any and all fees that may not be covered by my benefits or insurance.

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Signature of patient or responsible party Date