eye2eye
OPTOMETRY CORNER

FINANCIAL POLICY

1. **PAYMENT** for all professional services is due at the time services are provided.

2. **INSURANCE** companies do not pay 100% of all procedures. If you owe a balance after a claim is filed with your insurance company, a statement will be mailed to you. Deductibles, co-payments and non-covered benefits must be considered. Benefits are not determined by our office. It is the responsibility of the patient to know his/her benefits. If incorrect or expired insurance information is provided, the patient will assume full financial responsibility.

3. **LATE CHARGES** of $8.00 per month will accrue on all outstanding balances after 30 days.

4. **RETURNED CHECKS** will incur a $25.00 service charge.

5. **NO-SHOW FEE** of $25.00 is charged to all Saturday appointments missed or not cancelled within 24-hours.

6. **LEGAL ACTION** to collect unpaid charges will include the cost of attorney services, court costs, and a collection fee of 25%, in addition to any unpaid balances.

7. **REFRACTION** is the process of determining the need for corrective eyeglasses or contact lenses and is necessary to write a prescription. Most medical insurance plans, including Medicare, do NOT cover routine refractions or routine examinations. The fee for a refraction is $40.00 and is collected at the time of service in addition to your medical plan co-payment. If you have a separate vision plan, the refraction is likely covered.

8. **EYEWEAR and CONTACT LENSES** are special order items and once ordered cannot be cancelled. Exchanges can be made within 30 days of the sale/order date. Frames are subject to 15% restocking fee and lenses will be 50% off of the retail price.

By signing below, I acknowledge that I have read, understand and accept this Financial Policy.

Signature of Patient or Legal Guardian: _____ Date: _____

Patient's Printed Name: _____