Patient Financial Policy

THE Vision Care CENTER

Patient Name: _____

Thank you for choosing The Vision Care Center as your eye care provider. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc).

Co-pays
All co-payments are due at time of check-in. If the co-pay amount is unknown, our policy is to collect $30.00 at the time of service. We accept cash, check or credit cards. Absolutely no post-dated checks will be accepted.

Insurance Claims
Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company does not pay for any of your services performed at our office, you may be responsible for the complete balance of the non-payable services. If we are out of network with your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

Refraction Charge
The refraction (92015) is a non-covered service in the Medicare program. It is our policy to charge and collect any due refraction fee upon check out of the office.

Returned Checks
The charge for a returned check is $25 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check.

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.

Outstanding Balance Policy
It is our office policy that all past due accounts be collected in full. Balances are due upon receipt of your Explanation of Benefits (EOB) or a balance due statement from our billing company. If payment is not made on this account, you must contact our billing office to make payment arrangements. Unresolved balances may be subject to further collection activity and may be referred to a collection agency.
In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collections costs including reasonable attorney fees, court costs and other collection expenses incurred by The Vision Care Center.

Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other personal party.

*Federal Regulations require that The Vision Care Center obtain written acknowledgement by patients that The Vision Care Center has provided them with a copy of THE VISION CARE CENTERS NOTICE OF PRIVACY PRACTICES.
Please initial below acknowledging the receipt of this notice.

_____

I have read the above financial policy and understand my financial responsibility to my healthcare provider.

_____ _____
Patient / Guardian Signature Date