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 financial responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc). All co-payments are due at time of service. We accept cash, check or credit cards. We do not accept post-dated checks. 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.

Insurance
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
It is our policy to charge and collect any due refraction fee based upon your insurance plan at time of service.
**This is separate from a copay or deductible.*

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.

Past due patient accounts that do not have agreed upon financial arrangements with The Vision Care Center will be submitted to a collection agency Cash-Pro, Inc., or attorney for collection. I/we agree that I/we will pay all attorney fees and court costs incurred in the collection of all sums due.

I/we have read this disclosure and agree that I may be contacted by the facility, its' employees, agents, attorneys, and collection agencies. I/we agree that I may be contacted by calling or text messaging any phone number, including cellular phone numbers I/we have provided The Vision Care Center, which could result in charges to me/us. I/we authorize Cash-Pro to contact us on our cell phone number by using prerecorded artificial voice messages and/or use of an automatic dialing device. I/we understand that any e-mail address I/we provide is our personal e-mail address, and I/we authorize Cash-Pro, or its agents to contact us via that e-mail address.

*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.

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

_____ _____
Patient I Guardian Signature Date