# *FINANCIAL POLICY*

**INSURANCE POLICY:** Your insurance policy is a contract between you and your insurance carrier. **You are** responsible for providing our practice with the correct insurance information at the time of service or you may be responsible for the charges in full. **We file your primary insurance for you as a courtesy; however, the ultimate responsibility for payment is yours.** Should your insurance company fail to pay the insurance claim for services rendered, **YOU will be responsible** for the entire charges submitted to the insurance carrier. Therefore, we recommend that you follow-up with the insurance carrier if your claim has not been paid within 30 days from the date the services were rendered. If a follow up appointment is needed, **we file to your primary insurance as a courtesy; however, the ultimate responsibility for payment is yours.** We will not deny care to any patient. If we are not in-network with your plan, your portion of fees will most likely be higher. **Ultimate responsibility for payment of fees is yours**.

_____ I understand that I am responsible to pay for all services rendered, including the collection fees, attorney fees up to and including court costs if I default.

_____ I understand that if my routine benefits are out of network, I will be responsible for my comprehensive exam today.

_____ I understand my insurance benefits will not cover the contact lens evaluation and management; there I am responsible for payment. Contact lens fees range from $89 to $179.00 and are charged in addition to the exam fee.

**Returned Check fee is $35.00**

**CO-PAYMENTS, DEDUCTIBLES, & CO-INSURANCE:** Patients are expected to pay **AT TIME OF SERVICE** all amounts known not to be covered by their insurance company. These amounts include contact evaluation & management, copayments, co-insurance, and/or deductibles. Payments may be made by cash, check, and/or credit card (MasterCard, Visa, Discover, American Express, Care Credit).

_____ I understand that if I have a high deductible insurance plan and if the deductible is not met, I will be required to pay once my insurance has been billed. I understand any balance will be my responsibility.

_____ AFTER 90 DAYS OF NON-PAYMENT, YOUR ACCOUNT GETS SENT TO COLLECTIONS FOR NON PAYMENT AND A $75 FEE WILL BE ADDED TO THE BALANCE DUE.

_____ If the amount paid to your account results in a credit, any amount below $75 will stay posted on the account and can be used for future services and materials.

**REFRACTION:** Refraction is the measurement of the focus error of an eye. It determines the set of lenses that will best focus the light entering the eye. The results of a refraction are used to: (a) determine the health and visual potential of an eye; (b) aid in performing tests such as visual fields; and (c) to prescribe glasses and/or contact lenses.

_____ Refraction is considered a "non-medical" service by most medical insurance companies and is therefore most usually a non-covered service. The REFRACTION FEE is $55.00. Should your insurance company fail to pay the insurance claim for services rendered, **you** will be responsible for the charges.

**OPTICAL SALES:** All our eyewear is custom made to order. It is your responsibility to report any issues within 30 days of receiving your eyewear. We will make every attempt to resolve any issues within those 30 days. If we are unable to resolve issues within those 30 days a 20% restocking fee will apply to returned eyewear. After those 30 days all sales are final.

**CONTACTS/RX CHECKS: Follow-up appointments for contacts/RX checks need to be completed within 90 days of the initial exam.** After 90 days, the patient is responsible for another exam, not covered by insurance.

**PRESCRIPTION:**

_____ I have received a copy of my eyeglass's prescription electronically through the patient Portal

**REFERRALS:** Some patients will be required by their insurance company to obtain a "referral" from their Primary Care Physician authorizing their visit to **Envision Ghent Optometry**. It is the patient's responsibility to obtain this referral and to be sure that the referral is communicated to **Envision Ghent Optometry** before the patient's visit. We will as a courtesy request the referral. It is still the patient's responsibility to follow up on the referral.

_____ A patient presenting at **Envision Ghent Optometry** without a required referral will be asked to sign a waiver by which he/she agrees to pay all charges generated by the visit, if a referral is not obtained to cover the visit.

_____ Patients are reminded that many Primary Care Physician offices will not provide a retroactive(backdated) referral.

_____ Patients presenting without a required referral and who do not agree to sign a waiver may be asked to reschedule their **Envision Ghent Optometry** appointments.

Patient Signature:_____ Date:_____/_____/_____