Financial Policy

Thank you for choosing Advanced Eye Care and Vision Gallery. We welcome you as a patient and look forward to helping you protect your vision for life. This notice is intended to enhance communication and understanding with our patients regarding your financial responsibilities for services received, and the role of insurance billing for your care and treatments. We want you to know we take our responsibilities seriously, including committing valuable resources to protecting your eye health and assisting you in the utilization of your insurance benefits. If you have any questions at any time, please direct them to the insurance or office manager.

For the insurance plans we participate in, our office will electronically file your insurance claim for you and agree to have your insurance pay us directly. This is a courtesy we offer to our patients. However, you must understand that if your insurance does not pay for services or materials you have received, you agree to the following:

- All professional fees, including exam and any additional testing are non-refundable**.**
- You are liable for all services and appointments received. *Appointments missed without adequate advance notice (generally 24 business hours preceding your appointment) are subject to a $95 cancellation fee.*
- Unless you are paying in full on the day of service, you agree to provide us with your current insurance information at the time of scheduling or at least 24 business hours preceding your appointment with us.
- All co-payments, co-insurance, deductibles or non-covered service(s) are due at time of service. A non-refundable $15 administrative fee will be applied to your account if these payments are not received before end of business day.
- For the insurance plans we participate in, you will receive an explanation of benefits (EOB) from your insurance carrier. It simply explains your benefits, services covered, your responsibility and payments made on your behalf. In some cases there may be a remaining balance on your account. You will be responsible for the remaining balance or any non-covered service(s).
- We will notify you of your remaining balance, if you fail to remit, you will incur a $15 service fee each time we attempt to collect from you. If no payment is made within **90** days, we will forward your case to a collection agency. To avoid this service fee, payment must be received by the due date.
- Your employer chooses among a multitude of plan options, with benefits that change frequently. These large variations in coverage make it impossible for us to know the details and restrictions of every plan. We therefore contact your insurance company for clarification of your specific benefits. However, they will not guarantee payment, and often provide us with inaccurate information. We can only share with you what they tell us, with the understanding that we will not know the full outcome of your claim until they send the EOB to us.
- If you are concerned about your coverage, it is essential that you know what is covered by your insurance plan by contacting your insurance company directly. For example, some insurers reimburse for annual vision examinations and others do not. Referral rules vary as well.
- Our office is always happy to serve you. If need a written referral from your primary care physician, please have it available at time of service (TOS). If you do not have the insurance referral in-hand, we require payment in-full at TOS. Our staff will then provide you with receipt you can submit for reimbursement; however, without required referrals, they may not reimburse you.
- In those infrequent situations where the insurance company has stated inconsistencies with the benefit plan either due to (but not limited to) benefit type, coverage termination or coordination of benefits, you must take an active role in the recovery and remittance of the claim. After 60 days of non-payment, we will send you a bill for payment due to us. We will keep your credit card #_____ (MC or Visa) and expiration date _____ to utilize should this situation arise.

Signing this form acknowledges that you have read our policy, accept full financial responsibility for payment and give us permission to bill your claim electronically and/or by mail.

Patient or responsible party name	Signature	Date