VISION SOURCE PROFESSIONAL EYECARE

Revised 12/31/24

Financial Policy

PROFESSIONAL EYE CARE (a Vision Source provider) is committed to providing you with the highest level of quality medical care and personal service. In our practice, we do everything possible to make our patients our first priority including working to hold down the costs of healthcare. We feel that it is the patient or guardian's responsibility to meet the financial obligations that you have made with both your insurance company and our practice. The following is a summary of our financial policies.

- Each new patient must complete a registration form prior to or at the time of his or her appointment. Registration forms are updated annually.
- Proof of insurance and identity must be provided on the date of service, otherwise the patient will be expected to pay in full for all services when services are rendered. If we are unable to verify insurance benefits, the patient will be expected to pay at the time services are rendered.
- Payments for services and materials may be made by Cash, VISA/MC, AMEX or Discover Card.
- If we are filing a claim for you, your contracted exam co-payments, coinsurance and deductible amounts will be collected at the time of service as well as any materials obtained.
- Not all services are covered by insurance nor do we accept all insurance plans; those items or services not covered will be due on the date of service (i.e. Refraction, Contact lens fitting, Screening Tests, etc.)
- Materials, such as glasses or contact lenses, are custom items and not eligible for return; See optical for materials policies before ordering and for special arrangements.
- Patients with outstanding balances must make payment arrangements before their next appointment with the doctor.

Insurance

- It is each patient's responsibility to understand his or her insurance coverage. As your healthcare provider, our relationship is with you, not with your insurance company. While filing of insurance is a courtesy we extend to our patients, all charges are your responsibility from the date services are rendered.
- Verification of your benefits is not a guarantee of payment. All payments are subject to the terms and allowances of your plan when services are rendered and claims are received and processed by your insurance company.
- If we have not received a payment or a denial from your insurance company within 45-days of submission, we reserve the right to bill you directly for the services.
- Statements will be generated when your claims are internally processed or the balance exceeds the 45-day maximum allowance for outstanding balances. A statement may not be generated for balances due under $10, however these amounts will remain on your account and will be due on the next service date. ***Statement balance amounts will be due within 30-days of statement date.*** If you find an error on your statement or have any questions, please contact us immediately to clear up any confusion or concerns.
- All account balances listed under your account's guarantor will be due prior to services being rendered. We will make every effort to notify your guarantor of any past due balances prior to your visit.

Credits & Overpayments / Returned Checks

- Per our patient's request, credits will remain on your account to be used for future visits unless you request those amounts be refunded to you. Overpayments will be refunded within 30-days upon written request.
- Returned checks will incur a $35.00 service charge. Payment for return checks are due upon the notice of the returned check and are payable by cash, money order, VISA/MC, AMEX or Discover ONLY. We reserve the right to refuse payment by check if a history of returned checks is established.
- Missed appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24-hours prior to your appointment time. Excessive abuse of scheduled appointments may result in added fees and / or a discharge from the practice.

I have read, understand and agree to comply with the Financial Policy as stated above. I agree to allow ***Professional Eye Care*** to file claims on my behalf and receive payment for those services as governed by contract. I acknowledge that all previous balances owed as well as current amounts due will be paid prior to my receipt of services.

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Patient / Guardian Name (Print)

_____ _____

Patient / Guardian Signature *Date*

All accounts not paid within 60-days of the due date may be subject to an assessed late fee of 1.5% and/or a dismissal from the practice and may be turned over to our Collections Agency and documented on your credit report. Accounts reported to the credit bureau are subject to a collection fee with a maximum of $25 that will be added to your total balance due and will be your responsibility. Past due balances of over $200.00 may be taken to small claims court.