179 York Road, Warminster, PA/ 215.674.2020

THE EYE CARE CENTER FINANCIAL POLICY FORM

Thank you for choosing us as the provider for your eye health. This form provides you with the Financial Policies of The Eye Care Center. Completion of this form, a copy of your insurance card (if applicable), and a photo ID is required at EACH visit prior to being seen by our providers.

Our fees are based on the finest care, skill, and time required for the appropriate treatment. As a courtesy to our valued patients, we will:

- Research your vision insurance coverage to advise you of available benefits
- Inform you of applicable charges
- File your insurance and will request payment of your benefit directly to our office
- Re-file your insurance for the second time within 60 days (if necessary)
- Follow all appropriate coding procedures for insurance filing
- Accept American Express, Cash, Care Credit, Debit, Discover, MasterCard, Personal Checks, Visa

Your responsibilities include:

- Notifying our office as soon as possible for late arrivals or need to cancel an appointment
- Understanding your own insurance policy (medical insurance, vision care, eligibility, deductibles)
- Understanding if our doctors are contracted providers with your insurance plan
- Providing current insurance information prior to your appointment
- Keeping our office informed of any changes in your insurance coverage or employment
- Providing all applicable referrals prior to or at the time of the visit
- Providing applicable payment at the time of your visit
- Completion of this form

Please read and initial the following specifics regarding our payment processes:

________ (Initials) I give permission for my insurance benefits to be paid directly to The Eye Care Center.

________ (Initials) I understand that if I do not have vision coverage or a proper referral, that I am responsible for payment in full at the time of the service.

________ (Initials) If I have a commercial insurance, I understand that I am responsible for the Specialist co-pay amount at the time of the visit. If I have Medicare, I understand that I am responsible for refraction payment on the date of the visit. Co-pays not paid on the visit date will incur a $20.00 late fee.

________ (Initials) I understand that some procedures performed in office are often separate billable services. I understand that many insurance companies apply these procedures/ tests to a deductible or co-insurance and, therefore, may not be covered for payment. I agree that I am responsible for this payment.

________ (Initials) I understand that a $30.00 returned check fee will be added to my account for any check returned by my financial institution. I also understand that payment of the check and fee will be due within 5 days of notification.

________ (Initials) If your insurance company fails to respond or does not pay within 60 days, we will forward the balance to you for immediate payment.

________ (Initials) I understand that should your insurance plan pay us after you have already paid for the same procedure/ visit, we will promptly refund any overpayment to you.

________ (Initials) A finance charge of 1.5% per month will be applied after 30 days to any outstanding account balance.

________ (Initials) Accounts unpaid after 90 days will be considered as delinquent and will be turned to a collection agency/ attorney. You will be also be responsible for the additional collection fees and court costs if applicable.

PATIENT NAME (printed): ____________________________ Date of Birth: ____________

SIGNATURE OF PATIENT/ RESP. Party: ____________________________ Date: ____________

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