

# Payment Policy

## **Fees for Professional Services:**

All fees for professional services are due in full on the day services are rendered.

## **Fees for Eyewear:**

Frame & lens fees are due on the day of ordering. If you have insurance coverage, overages and co-pays are due in full prior to ordering. Please review the *Frame and Lens Policy* for detailed warranty and cancellation policies.

## **Fees for Contact Lenses:**

Professional fees and fees for lenses are due in full prior to ordering. Patients with vision insurance must pay all co-pays and overages prior to ordering. Contact lenses can only be returned for credit. They must be intact, in their original packaging with no marking and received within 45 days of receipt. Custom orders cannot be returned for credit. Fitting and assessment fees are non refundable. Medical insurances do not cover contact lens care including assessment of existing contact lenses and refitting. Routine vision benefits such as VSP do not include any contact lens care including assessing existing contact lenses. Contact lens fees include corneal topography (\$38.00) as well as professional fees.

## **Optos (retinal scanning):**

Retinal imaging is included as part of our comprehensive exam. For insurance patients this scan is not included and an additional fee of \$42.00 will be charged. Macular pigment density testing is also included for this fee or if stand alone will be \$25.00

## **Patients with Insurance:**

We accept assignment for Medicare as well as VSP. We will also bill other medical insurances provided we are network providers. Complete coverage from medical insurance is most often not the case. Any unpaid balance is your responsibility. Co-pays, deductibles, and non-insured services are considered your responsibility. For non-contracted insurances the patient must pay for the services in advance. **A statement fee of \$20.00 for each statement beyond the first will be charged. (payment for any non-insured amounts must be received within 10 days in order to not occur additional fees) Accounts in arrears of 60 days are sent to outside agency for collection.**

Primary Insurer \_\_\_\_\_ policy \_\_\_\_\_ group \_\_\_\_\_

Address \_\_\_\_\_

Phone number for claims \_\_\_\_\_

Secondary Insurer \_\_\_\_\_ policy number \_\_\_\_\_

Address \_\_\_\_\_

Claim phone number \_\_\_\_\_

(If under spouse please add spouse's name, date of birth and social security number)

## **Patient Confidentiality:**

In compliance with all state and federal requirements our practice will protect personnel health information from disclosure to all parties with exception of those specifically authorized by either statute or by the patient. A copy of our policy is posted in the office and copies are available to all patients.

I have read and agree to the payment policy and frame & lens warranties.

\_\_\_\_\_  
Name

0807

\_\_\_\_\_  
Date