OPTICOLOGY EYECARE

Thank you for choosing Opticology Eyecare as your healthcare provider. We are honored by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Insurance Authorization/ Financial Responsibly:

As the patient it is your responsibility to provide Opticology Eyecare a valid current photo ID in order to avoid insurance fraud as well as current copy of insurance card(s) medical and vision. Please ensure you notify the front desk if you are not the primary insurance holder (i.e spouse, partner) Please alert the front desk if insurance has changed or discontinued.

Any treatment recommendations are made based on what is best for you, our patient; treatment is not recommended based on what your insurance will or will not cover. All emergency medical vision services, or any vision services performed without previous arrangements, must be paid for at the time of service. Vision insurance does not cover medical exams. As a courtesy, we will bill your insurance for services rendered. Opticology Eyecare will do it's best to provide you an accurate estimation for what will be paid by your insurance, but cannot guarantee what they will pay. ***It is our office policy to collect patients estimated portion (co-pays, deductibles and refraction fees) at the time of service.***

Outstanding Balances/Failure to pay:

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of service. I understand if a balance is not paid within 90 days, unless written financial arrangement has been established my account could be referred to collections. I understand that am responsible for an additional collection fee of 15% if my outstanding balance is sent to collections.

Missed appointments/Family appointments:

Failure to contact without advance notice, a fee of $25 for any missed appointment will need to be collected and paid prior to future office visits. For families 3 or more who want to be scheduled together a $25 deposit per person will need to be collected due to the amount of time each appointments takes. Deposits may be used towards exam, co-pays, materials or refunded after the appointment.

Signature:_____ Date:_____

Patient's Printed Name:_____