Financial Policy & HIPPA Privacy & Refraction Policy

Insurance Submission Policies

We will bill insurance claims to primary and secondary carriers as a courtesy to our patients. It is your responsibility to provide us with the most current insurance information. You must also have a referral, when requested, before being seen by our office. Payment in full will be required if the necessary referral was not obtained. We accept reimbursement from all participating insurance plans. Payment of co-pays, deductibles and non-covered options are due at the time of service. Parents/Guardian requesting treatment for a minor will be responsible for the payment on that account.

Collections and Returned Check Fees

All delinquent accounts will be sent past due and final notices. If there is no response to our notices within 30 days, you will be referred to an outside collection agency. If your account is referred to collections, you will be assessed a 30% administrative fee in addition to your outstanding balance. There is a **$30** charge on all returned checks. Accounts that do not resolve a returned check issues within 14 days of notification will be sent to collections and assessed a 30% administrative fee in addition to the $30 fee.

HIPPA Privacy Acknowledgement

By signing the receipt of notice of privacy practice; I acknowledge and agree that I have received a copy of the Notice of Privacy Practices for review and to keep for my records on the date identified below. I understand that the location may use and disclose necessary personal health information (for example: my name, address, subscriber identification number, eye exam information and or type of products provided) to another party to permit its administrative duties, provide me with the eye care services and products, process my vision benefits claims and communicate with me regarding vision care services provided by the location. **I authorize this location to submit my vision benefits claims to my plan sponsor or health insurance to receive reimbursement directly for services I have received.**

I can be assured that this location does not sell my personal health information of any kind to a third party for such parties own use other than what has been indicated above.

Refraction

Refraction is the process by which your doctor determines your correct prescription for your eyeglasses, this is done at all routine eye exams. This service is performed to determine your prescriptions for near and far vision. The refraction will also provide information about your eye-muscle balance, focusing strength and ability. If you have routine eye exam coverage, this is covered by your insurance.

IF YOU DO NOT HAVE ROUTINE VISION INSURANCE, A FEE OF $40 WILL BE COLLECTED TODAY FOR ALL ROUTINE EYE EXAMS.

If we receive payment on the refraction from your insurance company, our office will reimburse you in a timely manner. My signature below indicates that I agree to receive the refraction service and I accept full financial responsibility for this charge if it is not covered by insurance.

Please sign below that you have read and understand the above statements.

Print Patient Name:____________________________________ Date: ____________________

Patient/ Guardian Signature: ____________________________________