SALANDVISION

FINANCIAL POLICY

The following outlines the financial policies that our office follows. We encourage you to discuss your account, and ask any questions. Your understanding of our policy early on in your treatment process will prevent most concerns and issues in the future.

INSURANCE

All co-payments and/or coinsurances will be collected at time of service.
We will file claims on all visits and procedures to your **medical** insurance.
Accounts will be balanced to match the insurance explanation of benefits (EOB) and any remaining balance will be forwarded to you, the patient.
You are responsible for **ALL** balances **NOT** paid by your insurance.
Please remember insurance coverage is a contract between the patient and the insurance company. The ultimate responsibility for understanding your insurance benefits and for payment to your doctor rests with you.

REFERRALS

You are required to know whether or not your insurances require a referral, and obtain that referral before you are scheduled to visit our office.
We will require payment in full on the day of service if you do not obtain a referral.

NON-COVERED SERVICES

Insurance companies will only pay for services that they find "reasonable and necessary".
You are responsible for payment of any services denied by insurance.

REFRACTION SERVICE & FEES

Refraction is the process of determining if there is a need for eyeglasses, and is an **essential** part of an eye exam. It is considered a routine vision service and performed on all comprehensive annual eye exams.
Most medical insurance plans, including Medicare, **DO NOT** cover routine refractions.
The fee for refractions is **$75.00** and is collected at the time of service.

PAYMENT

Payment must be made by: Cash, Check, Credit/Debit Card, and Money Order.
Cards accepted: **VISA, MASTERCARD, AMERICAN EXPRESS, and DISCOVER.**
A fee in the amount of $75.00 will be charged for all returned checks.

PAST DUE ACCOUNTS

Account balances should be handled promptly, and will be considered past due after 120 days with an outstanding balance. All past due accounts will be turned over to a collection agency, and a fee of up to 32% of past due balance will be added to your account.
We will require full payment before seeing the physician for any future services.

Print Patient Name:_____

Date:_____ Patient Signature: _____