PORTLAND EYE CARE

Financial Policy

Portland Eye Care is committed to caring for our patients and their complete eye health. Our doctors are trained to diagnosis and treat ocular diseases, therefore if a medical diagnosis is present (cataracts, glaucoma suspect, foreign body, diabetes, dry eyes, etc.) the exam is no longer routine vision and must be submitted to your medical insurance.

There are two types of health insurances that can be billed for your eye care services: vision plans and medical plans. It may be necessary to bill both types of insurance for your eye exam. Ultimately, you are responsible for any copay, deductible, co-insurance, and services not covered by your insurance plan.

The extent of your insurance benefit is defined between you, your employer, and your insurance company. As your eye care provider, our relationship is with you and not with your insurance company. While we file insurance claims as a courtesy, ultimately, all patient charges are your responsibility on the date of service. Payments can be made to Portland Eye Care by cash, check, or credit card.

We realize that a temporary financial crisis may affect timely payment. We encourage you to contact our office immediately for assistance in redefining the payment terms of your account. We would like to avoid any misunderstandings that may interfere with our positive relationship.

Primary Vision Insurance

Insured's Name: _____

Insured's Date of Birth: _____

Relationship to Patient: _____

Insurance Company Name: _____

Insured's ID #: _____

Group #: _____

Primary Medical Insurance

Insured's Name: _____

Insured's Date of Birth: _____

Relationship to Patient: _____

Insurance Company Name: _____

Insured's ID #: _____

Group #: _____

Secondary Vision Insurance

Insured's Name: _____

Insured's Date of Birth: _____

Relationship to Patient: _____

Insurance Company Name: _____

Insured's ID #: _____

Group #: _____

Secondary Medical Insurance

Insured's Name: _____

Insured's Date of Birth: _____

Relationship to Patient: _____

Insurance Company Name: _____

Insured's ID #: _____

Group #: _____

I acknowledge that I have read (or have been read) the financial policy and understand it. I agree that by signing this form, I am signing as a representative, patient, legal guardian, or guarantor, and that I am directly responsible for finances regarding this account. I agree to allow the doctor to bill my insurances accordingly to provide my best eye health.

_____ _____ _____

SIGNATURE OF PATIENT/GUARDIAN | RELATIONSHIP IF NOT PATIENT | DATE