VISION SOURCE™

Financial Policy

We are dedicated to providing the best possible care and service. Understanding of our financial policies is an essential element of care and treatment. To assist, we present the following financial policy. If you have any questions, please do not hesitate to discuss them with any member of our staff.

INSURANCE COVERAGE

It is your responsibility to provide our office with accurate information for billing your insurance plan properly at the time of service. It is also your responsibility to know whether your visit with us is covered by your insurance plan fully, partially, or not at all and whether your plan requires a referral from your primary physician before your visit. For example, you may be covered under your primary healthcare plan for additional vision care services under a different carrier. It is your responsibility to know whether you have this separate coverage. If at the time of service you only notify us of your primary healthcare plan and later make us aware of additional coverage under another plan, you will be responsible for any and all charges. We will gladly provide you with an itemized receipt to submit to your insurance for reimbursement. Information of this type is 100% accurate only if you obtain it directly from your health plan, not from our office staff. In the event you do not confirm this information and the insurer refuses full or partial payment, you will be held personally responsible for the cost of the services provided. Initial_____

ROUTINE AND MEDICAL EYE EXAMS

Our office participates with certain vision plans for "routine eye exams." A routine eye exam is, by definition, a "regular check-up" for someone with no eye problems. If the doctor detects any medical condition, (dry eyes, floaters, etc.) the exam may become a medical eye exam and will be submitted to your medical insurance. If your insurance plan requires a referral, you will need to obtain one for the exam. Due to insurance company regulations, routine and medical exams may not be performed on the same day. If you desire only the routine portion of the exam on your visit, the doctor may ask you to return another day for a medical eye exam. **Please note that some insurance plans consider a routine eye exam to be a non-covered service**.

Vision Plan Patients: I have read and understand the above routine eye care policy. Initial_____

SPECTACLE AND CONTACT LENS EXAMS

Exam for spectacles and contact lenses are separate exams. If you desire both exams on your visit, you will be charged an evaluation fee for a contact lens exam. We require this fee to be paid at the time of service. Initial_____

AMOUNTS DUE FROM THE PATIENT

We gladly accept cash, personal checks, Care Credit, and Visa and MasterCard. Insurance co-payments will be collected at the time of service. If we do not participate with your insurance plan, you are to provide payment in full at the time of service. We will provide you with an itemized statement of services and amounts paid which you may submit to your insurance. The insurance is then responsible for reimbursing you. If using insurance, we will make every effort to collect full and accurate fees specific to your plan. However, if there is a fee that your insurance charges and we did not collect it at the time the order was placed, it must be paid in full before glasses and/or contacts will be dispensed. Initial_____

AMOUNTS DETERMINED "NOT COVERED"

In the event a health plan determines a service of ours to be "not covered," you will then be responsible for the complete charge. An important example of this is our charge for checking eyes for changes in eyeglasses prescription and/or contact lens prescription (a procedure called refraction). We charge for this service and many insurances, including Medicare, deem this service "not covered." If we check your eyes for a change in glasses, you may be personally responsible for this charge. If you do not desire a refraction, please inform our office staff. Please note that some insurance plans consider a routine eye exam to be a non-covered service. Initial_____

I have read and understand the financial policies of Vision Source-Grayson Valley Family Eye Care and also understand that Vision Source-Grayson Valley Family Eye Care reserves the right to change any and all fees at any time.

_____ _____

Signature of Patient (or Responsible Party if Patient is a Minor) Date