Financial Policies Statement

General Policy

Our policy is to bill insurance claims as a courtesy for our patients. In order to bill your insurance claims correctly we need the following:

- **A copy of your most current insurance card**
- **Social Security number of both the patient and the responsible party.**
- **Your current address, which must match the address on file with your insurance company**

Patient Responsibility

Any fees collected at the time of service and any quotes regarding such fees are **estimated** based on the information available to us at the time of service.

If you are seeing the doctor for a medical condition, we will bill your medical insurance. If you are required to have a referral from your primary care physician, it is **your responsibility to obtain this prior to your visit.** If you do not obtain the referral, you may be responsible for all charges. If you require assistance in this matter, our office may be able to help. **It is your responsibility to know the benefits and coverage requirements of your insurance policy.**

Please note that most insurance companies, including **Medicare, do not cover refractions.** This procedure may be required at all your visits. If your insurance does not cover this procedure, you will be responsible for the charge.

Ultrasounds and **High Resolution Ultrasounds** are sometimes not covered by insurance companies. If this test is required for you and your insurance does not cover the procedure, you will be responsible for the charge.

If you are seeing the doctor for a **routine vision examination**, full payment is due at the time of service. If you have coverage for routine care we will bill your routine vision insurance. Please note that additional services such as contact lens exams are not typically covered by insurance companies. Therefore, you may be responsible for a fee. **It is your responsibility to know what your insurance policy covers. If a preauthorization is required, it is your responsibility to obtain this prior to your visit.**

All **copays, previous balances** and **non-covered services** are due **at the time of service**. If there is any balance due from you after your insurance company has processed your medical claim, such as a **deductible** or **co-insurance**, we will send a statement to your home address. **Balances are due upon receipt of the statement.** If payment cannot be made in full within 30 days of receipt, please contact our office to arrange a payment plan.

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any private insurance company's arbitrary determination of usual and customary.

Glasses are made specifically for you and your prescription, for that reason after the order has been started, they cannot be returned for a refund. We will do our best to ensure the frames fit properly and the lenses are made to our high standards.

I have read, understand and agree to this Financial Policy.

Patient Name_____Signature_____ Date_____

Acknowledgement of Receipt

I acknowledge that I received a copy of Insight Vision Group and Associated Eye Care Services LLC's Notice of Privacy Practices.

Patient Name_____Signature_____ Date_____