VisualEyes
Financial and Office Policies

Please initial each line below:

_____ All professional services rendered by VisualEyes are charged to the patient/guarantor. We will gladly file insurances in which we are providers. However, the patient/guarantor remains responsible for all fees regardless of insurance coverage.

_____ All co-pays, deductibles, and non-covered charges are due at the time of service, regardless of who brings the patient in for his or her visit. We accept cash, Visa, Mastercard, Discover, American Express, and CareCredit. Because of a dramatic increase in bad checks, our office no longer accepts personal checks as payment.

_____ Unless covered as part of a global surgery period, each and every office visit requires payment of a co-pay. **This policy is governed by YOUR insurance company and is not under our control.**

_____ It is the patient's responsibility to know your insurance benefits and whether our doctors are participating providers.

_____ If you have no insurance, payment for services is due at the time of service.

_____ No products will be dispensed without full payment. For glasses orders, at least half must be paid before the order is processed. Out of stock contacts must be paid in full before ordering. If vision insurance is involved, the patient's entire estimated portion must be paid before the order is processed.

_____ Any glasses or contacts ordered and left in our office past 60 days of initial order will be returned to stock. **Payments already made will NOT be refunded.**

Agreement to Accept Financial Responsibility, Insurance Authorization and Assignment of Benefits

I acknowledge that, at my request, VisualEyes has provided or will provide myself or my dependent with professional services and/or optical materials and I agree to the above financial policy. I also understand that if I fail to comply with this agreement, and if my account becomes more than 90 days past due, it may be turned over to a collection agency, an attorney, or small claims court for collection. I understand that any expenses incurred by VisualEyes in its effort to collect will be added to my bill and become my responsibility.

I hereby authorize VisualEyes to furnish medical information to my insurance carriers for payment of claims. I hereby assign to the doctors all payments for medical services and/or optical materials rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance.

Medical Record Release

I hereby authorize VisualEyes and/or any office staff, working on its behalf, to provide any/all necessary medical records, which is deemed beneficial, for referral to any other healthcare provider that VisualEyes deems necessary in promoting my treatment and care.

_____ _____ _____

Signature Relationship to Patient Date