Financial Policy

Thank you for choosing our office and allowing us to provide your eye care. We are committed to providing you with the highest level of care. The following is a statement of our financial policy, which we require that you read and sign prior to any treatment.

- Full Payment is due at the time of service.
- No refunds will be given on professional services.
- No refunds will be given on purchased glasses or opened boxes of contact lenses.
- Prescription eyeglasses remakes, for any reason, mayor may not be covered under your vision plan at no additional charge.
- We accept Cash, Check, Visa, Master Card, Discover and Debit Cards.
- Last minute cancellations or not showing for an appointment may result in a $30.00 charge to your account.
- There is a $50.00 return check fee, for all checks returned.
- If a health plan determines a service, like a refraction, to be "not covered," you will be responsible for the complete charge.
- Prescriptions for glasses and contact lenses will be guaranteed for 90 days after the prescription is finalized. If difficulties are experienced after 90 days, additional charges may be applied for further evaluation.

I HAVE READ THE ABOVE STATEMENTS: INITIAL ________

Important Information Regarding Insurance

You are required to pay your deductible and percentage that your insurance does not cover at each visit. We will be happy to submit a claim to your insurance company for you. We cannot bill your insurance unless you bring all your insurance cards, both vision and medical. Our office strives to provide high quality, dependable and ethical eye and vision care.

We see patients with "vision plans" like VSP, which cover a well vision exam and vision corrections. These are vision plans and only cover vision disorders correctable by glasses or contact lenses. If you have or if it is found that you have any medical eye condition, we are required to bill your medical plan if we are a provider. Payment for routine/preventative services is the responsibly of the patient, or patient's medical insurance or patient's vision plan if we are contracted providers.

When acting in the capacity of a contracted provider we reserve the right to judge which third party payer is the most appropriate to submit a claim for payment.

I HAVE READ THE FINANCIAL POLICY ABOVE. I UNDERSTAND AND AGREE TO THE TERMS OF THIS FINANCIAL POLICY.

Signature of responsible party ________________________________ Date ____________