



Financial Policy

The following information is regarding your account at Ideal EyeCare. If you have questions or concerns about any of the information contained below, please discuss them with our staff. We look forward to providing you and your family with excellent care for all of your eye care needs.

- Payment is due at the time services are rendered. This may include co-pays, deductibles, co-insurance, non-covered services, etc. For your convenience, we accept all major credit cards as well as debit cards, cash, and checks.
- It is your responsibility to know your insurance coverage and to provide our office with the most current and accurate information. While our staff is extremely knowledgeable about many insurance plans, we are not aware of every plan since they constantly change. We cannot be held liable for misquoted benefits or eligibility.
- The determination of your best corrected vision is called a **refraction**. This is considered a **non-covered service/procedure** by most insurance companies. You will be responsible for the **\$55.00** fee when this service is performed. We will bill this service to your insurance as a courtesy, and if they pay any portion, you will be refunded their payment amount.
- For those patients being followed for strabismus, a sensorimotor examination will be performed at each visit. This service is separate from the office visit and may be considered a diagnostic test by your insurance, resulting in additional out-of-pocket cost to you.
- If your insurance requires a referral, you are responsible for contacting your primary care physician/pediatrician to obtain said referral. It is also your responsibility to verify that valid referrals are on file for any follow up care.
- All "self pay" patients are required to pay in full at the time services are rendered. We will extend a 20% prompt-pay cash discount on all professional services and provide you with an itemized receipt.
- Our office does **not** accept insurance liens, workers compensation, or attorney liens. Payment is the patient's responsibility and due in full at the time of service.
- All returned checks are subject to a \$35.00 processing fee and will result in refusal to accept future payments by check.
- If the parents are divorced, the parent bringing the child for treatment is ultimately responsible for payment, regardless of the terms of any divorce decree or custody arrangement.
- All outstanding balances must be paid in full before scheduling surgery, except in emergent cases.
- All delinquent accounts may be sent to a collection agency and you may be charged any/all applicable collection fees. Once an account has been transferred to collections, you **and** your immediate family members will be **discharged** from the practice.
- Any account credit balance less than \$2.00 will not be issued a refund check.
- We will charge a \$25.00 per page fee for any and all forms that require the doctor's signature and review. This service will not be billed to your account or your insurance company. Payment is due before the form(s) will be released. A receipt will be provided at the time of payment.
- A **\$50.00** fee will be charged for all **NO SHOW** or missed appointments that are not cancelled within 24 hours of your scheduled appointment. This amount will be required before your next scheduled appointment. As a courtesy to all patients, we will try to notify you with a reminder call 48 hours prior to your visit. It is very important that you keep the front desk updated with your most current information.

I understand that even if Ideal EyeCare is contracted with my health care plan, I am ultimately responsible for payment of both covered and non-covered services performed during the course of my treatment. I request payment of authorized benefits by my insurance plan be made on my behalf to Ideal EyeCare for services rendered and request that Ideal EyeCare submit claims for payment for those services on my behalf to my insurance carrier. I authorize release of medical information to the insurance carrier or its agents to allow for benefit or claim determination.

Patient Signature/Legal Guardian Signature

Date

Please Print Patient's Name

Date

Thank you for choosing Ideal EyeCare!