 **FINANCIAL POLICY**

The following information is regarding your account at Ideal EyeCare. Please read these policies carefully and discuss any questions or concerns with our staff. We look forward to providing you and your family with excellent eye care.

* Payment is due at the time services are rendered. This may include co-pays, deductibles, co-insurance, non-covered services, etc. 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, coverages change frequently and we cannot be held liable for misquoted benefits or eligibility.
* 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 a valid referral is on file for all visits.
* 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. Strabismus patients are responsible for an additional fee of $40.00 for a prism refraction (total $95.00). 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.
* Telemedicine visits, whether scheduled or requested, will be billed to your insurance company and you may be responsible for out-of-pocket costs such as copays or deductibles.
* We do not participate with any vision plans and you are responsible for all “routine” and/or non-covered services provided to you or your child. This includes myopia management evaluations.
* All “self pay” patients are required to pay in full at the time services are rendered. We offer a 20% prompt-pay discount on all professional services and will 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 is due in full at the time of service.
* The parent bringing the child for treatment is 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 and attorney fees. Once an account has been transferred to collections, you ***and*** your immediate family members will be **discharged** from the practice.
* All returned checks are subject to a $35.00 processing fee and will result in refusal to accept future payments by check.
* Any account credit balance less than $2.00 will not be issued a refund check.
* We 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 insurance company. Payment is due before the form(s) will be released. A receipt will be provided at the time of payment.
* There is a **$50.00** per page fee for summary of care letters or other requests requiring a drafted and signed letter from the doctor.
* You will be assessed a **$50.00** **NO SHOW** fee for any appointment that is missed or cancelled within 24 hours of your scheduled appointment. You must pay this amount before you will be allowed to schedule another appointment. We offer reminder notifications be text/phone/email as a courtesy, but it is your responsibility to update your calendar. It is very important that you keep our office updated with your most current information.
* Per NRS 629.021, we charge $0.60 per page for copies of your medical record, whether provided via paper or electronic access. You may also be assessed applicable postage costs if you prefer to have the records sent via mail. These fees are waived if records are transferred directly to another physician for continued care.

I have read and understand the above information.

**Patient Name:** **Date:**

**Signature of Patient/Legal Guardian:** **Date:**