



## Our Financial Policy

Thank you for choosing us as your eye care provider. We are committed to your treatment being successful. 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**

### **WE ACCEPT CASH, CHECKS, OR VISA/MASTERCARD AND CHECK CASH CARDS**

## Insurance

All deductibles and co-pays are due prior to or immediately following treatment. In the event that we are not a participating provider, we require that you provide a credit card with authorization to bill the account for the balance. If we do file your insurance and it has not been paid within 90 days, the balance will automatically be transferred to your credit card. Please be aware that some of our services provided (such as refraction), may be non-covered services and not considered a part of the Medicare Program and other medical insurance.

## Usual and Customary

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 insurance company's arbitrary determination of usual and customary rates.

## Minor Patients

The adult accompanying a minor is responsible for full payment. An adult should accompany all persons under the age of 16 unless prior arrangements have been made.

Please let us know if you have questions regarding any of these policies.

X \_\_\_\_\_  
SIGNATURE

Date \_\_\_\_\_