

Financial Policy

You are responsible for services rendered and all products purchased. Out of pocket expenses are due at the time of service and prior to any material orders being placed. As a courtesy, we will bill applicable charges to your insurance company. After insurance has paid, we expect you to pay any remaining balance upon receipt of statement, as you are ultimately responsible for your bill. Any balances not paid after 90 days are forwarded to collections and additional charges/interest will apply. Returned checks will be assessed a non-refundable $35 charge.

If you do not have insurance or if insurance does not cover the services being provided, we offer a 25% discount off our professional fees, except for contact lens services and *Optomap* Imagery. This discount only applies if you pay at the time of check out. Eyes For Life also welcomes Care Credit. Credits applied to your account are available for use by patients listed on the same account and/or will be applied to any balances owing. Any overpayments due you are routinely reviewed and will be refunded whenever there is no balance owing on the patient’s accounts records.

The doctor may, on occasion, feel it necessary to perform additional medical testing or procedures in order to diagnose or treat any suspected or existing condition. These services are medical in nature and will be billed accordingly. Any outstanding balances not covered by your insurance are your financial responsibility.

**Cancellation Policy:** As of January 1st, 2016 you will need to give us 24 hour notice of cancellation or rescheduling as there may be a $35 reinstatement fee applied to your account prior to your next appointment.

**Assignment of Benefits**: I hereby authorize all payment of benefits payable to me or on my behalf to Eyes For Life for any services rendered by that facility. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Eyes For Life to release all information necessary to secure the payment. By signing below, I acknowledge receipt of and compliance with the Eyes For Life Contact Lens Care Instructions.