Financial Policy

_____ **Patient Financial Responsibility 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. We will charge a rebilling fee of $5.00 for rebilling. 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 **15% discount off our professional fees**, except for contact lens services and *Optomap Retinal Imaging*. 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 (such as copays and deductibles) are your financial responsibility.

_____ **Appointment Cancellation Policy:** To ensure we are able to provide the best experience to our valued patients, please give us 24 hour notice of cancellation or rescheduling. We do charge a no-show fee of $55 for the missed appointment.

_____ **Glasses Cancellation Policy**: If glasses orders are cancelled after the lab has begun the order, the patient will be held responsible for $250 restocking fee for the lenses. Our lens laboratories dictate this charge to cover their expenses for already started jobs.

_____ **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.

The Purpose of my visit today is to have a routine wellness eye exam to update my glasses or contact lens prescription.

☐ I have no medical concerns today.

☐ I have a medical concern to discuss with the doctor.

I understand the exam will be considered a **medical exam** if:

1) The purpose of my visit is to discuss with the doctor any concerning medical eye disease such as Glaucoma, Diabetes, Macular Degeneration, Floaters, Dry eye, etc.

2) The doctor discovers any emergent or concerning medical eye disease during my examination that needs to be further discussed or evaluated to provide the best eye care possible.

In this case, I understand my **medical insurance** will be used and may be subject to deductibles owed.

I accept financial responsibility for today's fees not covered by insurance.

Signature:_____ Date: _____

Eyes For Life has been given permission to contact _____
(ex: friend or family member who may answer your phone, pick up orders or schedule for you) on my behalf regarding all billing and medical concerns as needed. This authorization will stay in effect until I revoke it.

If this is your FIRST comprehensive eye exam with us, please explain how you heard about our office:

☐ Referred by friend or family member *(name):*_____

☐ Insurance Listing ☐ School ☐ Drive by ☐ Facebook ☐ Internet Search

Personal Acquaintance/Friend of: ☐ Dr. Maier / ☐ Dr. Robertson