

SOUTH RIVER EYE CARE FINANCIAL POLICIES

Thank you for choosing South River Eye Care as your vision care provider. The following is a statement of our Financial Policy. If you have any questions please direct them to our staff.

We accept cash, personal checks, Visa, MasterCard, American Express and Discover Card and select insurance plans for payment on your account. As health care professionals, we are not trained or equipped to administer money lending plans. We respectfully request that divorced families make private arrangements to split expenses. We will consider the parent with the child in our office to be the party responsible for making buying decisions and paying the bills.

PROFESSIONAL SERVICES

Payment for examinations and office visits are expected at the time of service. If a vision insurance plan is involved, your co-payment and/or the difference between the fee and your coverage should be paid at the time of service. If we are not able to verify your insurance coverage or eligibility on the date of service or if your plan requires special forms that you have not provided on the date of service, we will ask you to pay privately for your services and seek reimbursement from your plan. Because medical insurance plans vary so widely regarding co-pays and percentages covered, we will ask for your payment on the date of service for most medical visits and assist you in seeking reimbursement. We reserve the right to select the insurance plans from which we will wait for reimbursement.

MATERIALS

Our practice is committed to providing the finest eyewear products available. We have products available in a wide range of prices. Most eyewear products are custom made for your use. You are asked to pay a **minimum 50% deposit** to secure your custom eyewear order. Any remaining balance is due when your eyewear is picked up. Contact lenses must be paid in full before ordering. We welcome telephone orders secured by your credit card.

INSURANCE

Although our staff handles your insurance transaction as a service to you, **you need to carefully verify your own coverage and eligibility date.** Our office does not file for secondary coverage.

Release of medical information and assignment of benefits:

I hereby authorize South River Eye Care to release to the Health Care Financing Administration or any other third party payer any and all information necessary to process a claim on my behalf. I authorize South River Eye Care to accept payment from my insurance company. **I UNDERSTAND THAT PAYMENT FOR ALL SERVICES AND MATERIALS ARE THE ULTIMATE RESPONSIBILITY OF THE PATIENT AND THAT I WILL BE REQUIRED TO PAY ANY BALANCE LEFT UNPAID BY MY INSURANCE AFTER 60 DAYS FROM THE DATE OF SERVICE.**

Signature of responsible party _____ Date _____