

Financial Policy

PAYMENT:

For all services, accessories, glasses or contact lenses ordered or provided by the physicians and staff of Forester & Pitt Vision Source, payment is due at the time of service or when product is ordered. This includes your portion that insurance will not pay including any co-pay, deductible and/or co-insurance amounts. We accept Visa, M/C, American Express and Discover for your convenience. We also accept cash and personal checks. The return check fee is \$35.00.

INSURANCE:

At each visit to our office, we will ask you for a copy of all of your current insurance card(s) and if you have had any changes to your insurance. As a courtesy, we will bill your insurance company for the covered services provided to you. However, it is *your responsibility* to know the benefits and conditions outlined in your insurance plan. Most insurance policies pay only a portion of your total charges. We do not guarantee the accuracy of benefit information given to us by insurance companies. If for some reason your insurance company fails to pay, we will expect you to pay the balance in full. If you *have not* met the deductible amount for the current year, and the insurance company applies your covered charges to your annual deductible, you will be billed for the amount of the service(s). Payment will be required in full within 15 days of the date on your monthly statement. If insurance information is not provided the day of service, you will be responsible for filing the claim yourself.

By signing below, I authorize the release of any medical or other information necessary to process my insurance claims.

MEDICARE:

For patients who have Medicare, you must have **PART B** coverage for Medicare to pay your claim. You will be responsible for any charges Medicare or your supplemental insurance does not cover. This may include, but is not limited too: deductibles, refractions, eyewear, Optomap, and other testing our doctors may order.

NON-INSURANCE:

For patients without insurance, payment is due at the time service is rendered.

PRODUCT:

A 50% deposit is due at the time materials are ordered. The remaining balance is due at the dispensing of materials. This office is not responsible for any material(s) left after 90 days. Deposits are non refundable.

RESTOCKING FEE:

In the event that you cancel an order for custom items (which would include all glasses and/or specialty contact lenses), if the job has already been started by the lab, you will be responsible for a restocking fee of 25% of the entire custom order.

LATE FEE:

A late fee of \$25.00 will be added to your balance each month (30 days) the account is past due.

Thank you for taking the time to read our financial policy. We hope this answers any questions you may have. If you have any further questions, please do not hesitate to ask.

I have read, understand, and agree to the conditions above.

Patient Signature (or Guardian if patient is a minor)

Date