OUR TOWN EYE CARE

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Our Town Eye Care Patient Financial Policy

Welcome to Our Town Eye Care. Thank you for choosing us for all of your eye health needs. Our goal is to make you feel welcome and to provide you with the best eye health care possible. Please take a few moments to review the following information:

- Payment is expected at the time that services are rendered – this includes co-pays. As a courtesy, we will file your insurance claim today on your behalf. Any balance not covered by your insurance (co-insurance fees or if your deductible has not been met) will be billed to you. Any balances that remain after 60 days, or balances due to an underpayment or denial by insurance will become the patient's responsibility.
- If your insurance plan requires a referral authorization from a primary care physician, the patient is responsible for presenting the referral at the initial appointment. Your insurance may deem the appointment "out of network" or "non covered" treatment, and in this case you will be responsible for all charges incurred. You acknowledge that it is your responsibility to be aware of what services are covered and you agree to pay for any service deemed to be non-covered or not authorized.
- Payment options include: cash, check, debit or credit card (MC, VISA, DISCOVER, AMEX), and Care Credit (a financing plan that offers no interest payments for 6 months to qualified applicants).
- A 50% deposit is required on all eyewear orders. The balance is due upon delivery.
- There will be a $35.00 charge when a check is returned from the bank due to "*non-sufficient funds*".
- If your account becomes past due, we will take all necessary steps to collect this debt. If we have to refer your account to a collection agency, you will be responsible to pay all collection and legal fees that are incurred.
- (*If using insurance*) I authorize the release of any medical information about me that is necessary to process an insurance claim and I further authorize payment of my medical insurance benefits to Our Town Eye Care.

By signing below, I agree to abide by this Financial Policy.

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Signature, Patient, Parent and/or Guardian Date