



## FINANCIAL POLICY

**Dear Patient,**

We are committed to providing you with the best possible care, and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. We must emphasize that as health care providers, our relationship is with **you**, not your insurance company. Therefore, we have developed the following financial policies:

- **The Wise Vision Group cannot guarantee any benefit, level of payment or coverage by your insurance plan.**
- **You are responsible for notifying the office of changes to your demographic information.**
- **You are responsible for notifying the office of any changes to your insurance coverage.**
- **We must have a current copy of your insurance card to submit your claim for payment. Due to medical insurance fraud issues, please present your Driver's License or ID card to receive services.**
- **Your insurance plan may not cover certain medical services for certain conditions. It is your responsibility to know your plan benefits.**
- **Your insurance plan document will ultimately determine the level of service provided for care in our office. It is your responsibility to know your plan benefits.**
- **Your insurance may or may not cover a non-medical vision exam. It is your responsibility to know your plan benefits.**
- **Patients covered under a PPO/HMO/EPO/POS plan are responsible for complying with all rules that are required by your plan, including using network providers, and obtaining necessary referrals and authorizations.**
- **Failure to comply with requirements of your particular plan will make it necessary for us to bill you directly for charges.**
- **Co-payments must be paid on the day service is provided. Known co-insurance and deductibles are payable at the time of service.**

Payment for care is due at the time services are rendered, unless our office has approved payment arrangements in advance. You are responsible for timely payment of your account. If for any reason you experience financial problems that may affect timely payment of your account, we encourage you to contact our office.

As a patient of The Wise Vision Group, I understand that if I do not pay the entire new balance within 15 days of the initial billing, a service charge and/or interest fee will be added to the account for each subsequent statement issued. If I do not pay my bill in a timely manner (**within 15 days**), I understand there will be a rebilling fee for each subsequent bill sent (15 day cycles) and that a third party may become involved to collect my balance if it remains unpaid after statement notice. In the case of default of payment, I understand that a third party may collect my balance. **I understand that if a third party is utilized to collect my balance; there is a service fee for the transfer of my account.** I promise to pay any service charges and/or interest on the balance due, together with any reasonable collection costs and/or reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

Thank you for understanding our need for a **Financial Policy**. If you have any questions about the above information, please ask for clarification. We are here to assist you.

**I have read the above information; I understand and agree that I am responsible for the payment of all professional services rendered, all co-payments that apply to my account, any service or collection fees, as well as any charges not covered by my insurance.**

\_\_\_\_\_  
**Patient/Responsible Party Signature**

\_\_\_\_\_  
**Date**