



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.

- **You are responsible for notifying the office of any changes to your insurance.**
- **We must have a current copy of your insurance card to submit your bill for payment.**
- **Your insurance may or may not cover a non-medical vision exam. It is your responsibility to know your benefits.**
- **Patients covered under a PPO/HMO/EPO/POS plan are responsible for complying with all rules that are required by your plan.**
- **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.**

Payment for service is due at the time service is 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.

If I do not pay the entire new balance within 30 days of the monthly billing, I understand a service charge and/or interest may be added to the account for each subsequent statement issued. In the case of default of payment, I promise to pay any service charge and/or interest on the balance due, together with any reasonable collection costs and 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