Gene O. Teigen, O.D.

EYEDENTITY
EYECARE + EYEWEAR

Grant W. Hardan, O.D.

FINANCIAL POLICY

Thank you for choosing EyeDentity Eyecare + Eyewear for your vision and eye-health needs. The goal of our doctors and staff is to provide you with thorough, professional eye-care and quality products that exceed our patient's expectations. Your understanding of our financial policy is an essential part of your care. If you have any questions regarding this policy, please feel free to discuss them with our staff.

FULL PAYMENT FOR PROFESSIONAL SERVICES IS DUE AT TIME OF SERVICE. This includes: all co-pays, Medicare refractions, fees for non-insured patients, and contact lens fitting fees. Acceptable forms of payment include: cash and personal checks. Also, for you convenience, we accept Visa, MasterCard, Discover, and Care Credit. A $30 FEE WILL BE CHARGED FOR ALL RETURNED CHECKS.

If services are provided for a minor patient, the parent/guardian accompanying the patient is responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless accompanied by a parent or guardian.

In order for us to bill your insurance company you need to provide the necessary information prior to the appointment. If you are unable to provide us with this information, you will be considered private/cash pay. As a courtesy to our patients, if you have supplied us with a current vision insurance policy or medical insurance that covers eye-care, we will verify your eye exam and hardware benefits prior to your appointment. We will also bill your insurance company for office visits, exams, and hardware, on your behalf. In doing this, we will bill and receive payment directly from your insurance company for covered services. We will do all we can to assist you in obtaining your maximum allowable benefits.

If you are using your medical health insurance, it should be understood that you may have co-insurance or deductable fees due after insurance is billed. Also, please be advised that most medical insurances do not cover routine eye exams. If a referral is required by your insurance, it is the responsibility of the patient to obtain authorization prior to your visit. While we are contracted with many insurance companies, not all services are a covered benefit in all contracts and routine eye-care and other specialty testing/procedures may be specifically excluded, making the patient responsible for the charges. Also, benefits may vary if we are out of network. It is ultimately the responsibility of the patient to know your plan benefits.

Your insurance contract is an agreement between you and your insurance carrier. We are not a party to that contract. If your insurance company denies payment, or has not paid your account in full within 60 days, as required by state law, the balance will be automatically transferred to you. For any remaining balance due after your insurance company pays, we will send you a statement. If there is no payment after 30 days, late fees will incur. Please call if you have any questions about your bill.

We prefer payment in full upon ordering glasses or contacts; however, we will allow you to make a 50% deposit to initiate your order, with the remaining balance to be paid in full when the order is dispensed.

Materials including: eyewear, glasses, contact lenses, accessories and supplements are all NON-REFUNDABLE. Prescription optical materials are customized and fabricated specifically for each individual patient. Once these items are ordered they become the financial responsibility of the patient. If the prescription itself is not to your liking, you may bring the glasses back within 30 days and have the frame and/or prescription adjusted to resolve any issues. Contact lenses may be eligible for exchange and will be handled on a case by case basis.

We reserve the right to turn any patient over to a collection agency if it is deemed that the account has been in default of payment. If we turn your account over to a collection agent, you will be responsible for any administration fees, attorney fees, and/or court cost incurred.

I certify that I have read, understand, and agree to the Financial Policies noted above:

Print Responsible Party Name: _____ **Date:** _____

(Patient or parent/guardian if patient is a minor)

Signature of Responsible Party: _____