

Financial Policy Statement

To help our patients fully understand our billing process, we ask that you read and sign our financial policy statement.

As a courtesy to you, Family Vision Care will submit a claim to your insurance carrier. Depending upon your individual policy, your coverage, your deductible and/or co-payment requirements, you may be billed for the balance.

Although Family Vision Care participants with most insurance carriers, it is your responsibility at the time of service to verify your insurance carrier if the particular physician, or the service/ test that you are scheduled to have is accepted by your plan.

For claims not submitted as a courtesy, Family Vision Care accepts cash, checks, debit cards, MasterCard's, Discover cards, and Visa for payment. For insurance plans that do not allow courtesy submission of claims, you must pay at the time of service.

When our Doctor participates fully in your insurance plan, you are still responsible for paying any co-insurance, deductible or co-payment (s) as indicated by your carrier, as well as any non-covered service(s) under their contract. Once payment has been made or payment has been denied by the insurance company you will be billed and be responsible to pay the balance.

You are responsible for bringing the necessary referral(s) to the office on the day of your appointment. If you do not have the required referral form(s) on the day of the appointment, you are responsible for payment at the time of service.

Although Family Vision Care may on occasion, as a courtesy to you file private insurance claims, we will not become involved in disputes between you and your insurance carrier regarding covered charges, secondary insurance issues or "usual and customary" charges other than supply factual information as required by the insurance carrier.

Thank you for taking the time to review the Family Vision Care financial policy statement. Please let us know if you have any questions, comments or special concerns!

Responsible Party Signature _____
Print Name _____ Date _____