



# Crete Family Eyecare

## Financial Policy

Thank you for choosing Crete Family Eyecare. We are committed to providing excellent service in every area of our facility including billing and insurance claim filing. If you have any questions about this financial policy, please feel free to discuss this with our billing staff. We are here to help.

**Patients will be expected to show a valid photo ID as well as all their insurance cards at every visit.**

Crete Family Eyecare participates with many health and vision plans. As a courtesy to our patients, we will file claims on your behalf to these companies. Your insurance contract is an agreement between you and your insurance carrier. It is ultimately your responsibility for the full and timely payment of your account.

### **Insurance**

In most cases we will run an insurance verification prior to your visit. This verification will let us know what out-of-pocket expenses you are likely to have at the time of your visit. While we may estimate your financial responsibility, it is your insurance carrier who ultimately makes the final determination regarding your eligibility and benefits.

Certain office procedures or services may not be covered or may be considered “not medically necessary”, “experimental”, or “cosmetic” by your health plan. You are responsible for payment of these services. You are responsible to know the benefits and limitations of your current health or vision care coverage. Crete Family Eyecare provides services and care based on a patient’s need, not based on a patient’s insurance coverage.

### **Patients Who Are Minors (18 years old or under)**

The parent or guardian accompanying a minor is responsible for full payment. For unaccompanied minors, written or verbal consent, to see and treat according to minors’ symptoms, will be needed prior to the exam. All items not covered by insurance will need to be paid at the time of service, regardless if a guarantor is present or not.

### **Methods of Payment**

We accept cash, personal checks, VISA, Master Card, and Discover. We also offer Care Credit, which is a financing option for any healthcare related expenses. If you are interested in Care Credit, please ask our administrative staff for details and a credit application.

### **Missed Appointments/Failure to Cancel Appointments**

Please help us serve you better by keeping scheduled appointments or calling us in advance (at least 24 hours) to reschedule an appointment.

### **Glasses and Contact Lenses**

Full payment is due at the time glasses and contact lenses are ordered. All prescription optical materials are custom made and fabricated for each individual patient. **Any materials not picked up within 90 days will be returned to stock with no refund.**

### **Contact Lens Fees**

If you currently wear contact lenses, or wish to start wearing them, there are separate charges for the contact lens exam or the contact lens fitting. Wearing contact lenses requires additional testing and evaluation of the fit of the lenses to ensure your eyes remain healthy while wearing lenses. The charges for these services are due at the time of service.

### **Insurance**

Payment will be **DUE AT THE TIME OF SERVICE** for all amounts known to not be covered by your insurance company. These amounts may include **co-payments, refraction fees, medical testing, contact lens fees, optical purchases, deductibles, co-insurance,** and/or any known non-covered services.

### **Refractions**

A comprehensive eye exam has two components: 1. the eye health exam and 2. the refraction. The refraction is the testing process to determine if there is a need for glasses or if there is a change in prescription for someone who already wears glasses. This allows us to give you a final prescription so that you may order glasses and also gives us a starting point for fitting contact lenses if desired. Refractions may be done for a routine exam or for a medical exam. Most insurance plans do not cover the cost of a refraction. *Medicare does not cover the cost of a refraction.* You will be asked to pay for the refraction at the time of your visit.

### **Billing**

Statements will be mailed weekly and payment is due in full upon receipt. If a check is returned for insufficient funds, account closed, or payment stopped, **your account will be charged a \$30 fee.**

### **Past Due Accounts**

We are happy to assist in the filing of any medical or insurance plan that we participate in. Once all claims have been filed, you will receive a statement with your remaining financial responsibility. We appreciate your prompt payment of that responsibility. Should there be a delay in receiving payment, **there will be a \$25 per month late fee assessed to any unpaid balance past 30 days.** If you have not paid your bill or contacted us to make arrangements, your account may be referred to a collection agency. The patient or guarantor agrees to pay for any costs of collection or legal fees related to these collection efforts, in addition to the account balance.

### **HIPAA**

By signing this form, you acknowledge that you have been offered and/or received our "Notice of Privacy Practices". This Notice describes in detail how we might use or disclose your protected health information. The Notice also discusses your rights and our duties with respect to your protected health information. You have the right to review the Notice before signing this policy.

*By signing below, I acknowledge that I have read and/or received a copy of Crete Family Eyecare's Financial Policy and agree to be bound by its content. I also authorize the release of any medical information necessary to process all insurance claims. I further authorize the release of payment for medical and/or vision plan benefits go directly to my physician.*

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Patient or Guarantor Signature

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Date