Financial Policy

Thank you for choosing our office and allowing us to provide you with the best possible eyecare. The following is a statement of our financial policy, which we require that you read and sign prior to any treatment or services.

Cascade Eyecare

Providing the best possible eyecare

1. **Insurance Benefits.** We will bill your insurance as a courtesy for you. If you provide us with your current insurance information and most current insurance cards, we will do our best to verify your benefits prior to receiving care, however insurance companies will never allow a quote of coverage a guarantee of payment. We will collect 100% of services not covered by your insurance carrier on the date of service. If you have a co-payment, co-insurance, or an unmet deductible, you will be responsible for payment at time of service**. We do offer services and products that may not be covered by your insurance and you will be responsible for the balance on the date services rendered.** Please be aware that some patients' policies are written to where they may have a deductible for services and/or a co-payments for certain services. ****Insurance is a contract between the patient and their insurance carrier, it is important that you take responsibility for understanding your benefits. ****

I have read the above paragraph and understand that I am responsible for my insurance balance. __________ (Initial)

2. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we are contracted with, payment in full is expected for each date of service.
3. **Medical Visits.** If treatment by the doctor is considered a medical procedure, rather than a vision care procedure, we will process the visit as a medical claim. For questions regarding major medical benefits, we ask you to refer to your medical insurance company.
4. **Co-Payments and Deductibles.** **ALL CO-PAYMENTS** must be paid at the time of service. This arrangement is part of your contract with your insurance company. ***Please understand we are required by law to collected co-payments from our patients at the time of service.***
5. **Non-Covered Services.** Please be aware that some – and perhaps all – of the services you receive **(*i.e. Refraction, RTA Scan, and Contact Lens Fittings/Evaluations*)** may be non-covered or not considered reasonable or necessary by Medicare or other insurers; in this event the patient is responsible for all non-covered charges.
6. **Proof of Insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your current valid insurance card to provide proof of insurance and picture ID. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for the balance of the claim.

7. **Claim Submission.** We will submit your claims and assist you in any way we reasonably can to help get your claim processed. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their requests. *Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.* **Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.**
8. **Coverage Changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

9. **Cancelled Orders.** Any orders canceled after 48 hours may be subjected to a 20% cancelation fee. For restocking purposes.
10. **Late Cancellation Appointment.** Late cancellations or not showing up for an appointment may result in $50.00.

Prescriptions for glasses and contact lenses will be guaranteed for 90 days after the prescription is finalized. If difficulties are experienced after 90 days, additional charges may be applied for further evaluation.

I have read and understand the financial policy and agree to abide by it guidelines.

Signature of Patient: ______________________________ Date: ______________

Patient's Representative Signature: ______________________________ Date: ______________

Description of Representative's Authority: ______________________________