ACCURATE
VISION CLINIC

PATIENT FINANCIAL RESPONSIBILITY, BILLING POLICY, & PROCEDURE

Patients with Insurance It is your responsibility to provide your insurance information. Without complete insurance information Accurate Vision Clinic cannot bill for services. Proof of insurance is required at the time of service. Insurance is a contract between you and your insurance company. As a courtesy to you we will file your claim but you are ultimately responsible for all charges regardless of what your insurance does or does not pay. Your co-pay and any unmet deductible will be collected at the time of service. If you do not know what your co-pay is, we will collect 20% of the balance.

Patients without Insurance All charges incurred at the time of service must be paid in full at the end of each appointment. For payment in full at time of service, we offer a 10% discount. If you are unable to pay in full at the time of service you must establish an approved payment plan with Accurate Vision Clinic's billing department.

CareCredit Financing We offer CareCredit to you as a financing option so that you are able to make convenient, budget-friendly monthly payments, if needed. CareCredit offers 6 and 12 month no interest plans and longer-term payment plan options with interest to its clients. We will be glad to help you apply and answer any questions you may have.

Office Policies A statement of your account will be mailed to you if an outstanding balance exists. Payment in full is expected within 30 days after the insurance company has made its determination of payment or 90 days from the date of service whether or not insurance has responded. If a third statement has been sent, a late fee of $30 will be added to the account. Failure to pay your account within 90 days from the date of service will result in collection proceedings. Should circumstances prevent you from paying your account in a timely manner, prior to commencement of collection activity please contact our billing department to make other arrangements for payment. Patients with delinquent accounts may be permanently discharged from our practice. Returned checks for non-sufficient funds (NSF) will incur a $25.00 NSF fee. Refunds over $40 will be issued by check to the account holder. If a refund is less than $40 this will be applied to the account as a credit to be used for future services.

I, the undersigned, authorize payment of medical benefits to Accurate Vision Clinic for any/all service provided to me by the physician. I understand that I am financially responsible for any amount not covered by my insurance plan. I authorize Accurate Vision Clinic to release information concerning my health care, advice, treatment, and/or supplies to my insurance company and/or it's agents for the purpose of evaluating and administering claims. I understand that if I do not have insurance coverage payment is due in full at time of service unless an approved payment plan has been established.

Print Patient Name _____

Patient or Guardian Signature _____ **Date** _____