Financial Responsibility Statement/Acknowledgement of Office Policies

Financial Policy

Payment is expected at the time service is rendered and before orders are placed. A $25.00 service fee will be assessed for failure to pay your requested copay at the time of service. A returned check will incur a fee of $25. Any unpaid balances exceeding 30 days post notice of balance owed may be turned over to a collections agency, which will result in an additional fee equal to 35% of the balance owed plus an administrative fee of $25. A cancellation fee (amount varies based on total time scheduled) may be assessed for any appointment missed without at least 24 hours prior notice. By signing you agree to be held liable for all expenses, costs and reasonable court, attorney and collection agency fees for any delinquent balance.

Prescription Recheck Policy

We will recheck your glasses prescription one time at no cost within 60 days of the date on which the prescription in question was determined. This policy does not apply for planned rechecks as determined by the doctor for issues such as expected adaption or amblyopia. For glasses not purchased through our office an inspection fee for confirming the parameters of a prescription pair of glasses will apply. After 60 days, a fee will be incurred for any recheck. Rechecks will not be performed after 6 months from original exam date and a new exam will be necessary.

Eyewear Policies

This office will remake prescription glasses once within 60 days of pickup at no charge to the patient in cases of prescription change. Progressive lens non-adapts will be remade into lined bifocals or trifocals at no additional charge. Any remakes required beyond the initial remake will result in fees for the lenses and any treatments charged at 50% of our usual and customary fees.

Frames purchased from our office have a 2 year manufacturer defect warranty and does not cover acts of abuse. Lenses with a scratch treatment have either a 1 or 2 year warranty, depending on type of scratch treatment purchased, which covers wear and tear scratches but not acts of abuse. Neither of our warranties for frames or lenses cover loss or theft. If you used insurance to purchase your glasses your warranty changes from our standard office warranty to your insurance company's warranty.

If you wish to be reframed, you may do so once for a $50 administrative fee for frames of equal or lesser value. You may select a frame with a higher value and pay only the difference in frame cost and the administrative fee. Reframing will count towards your one time remake option. A $50 administrative fee will be charged for same day cancellations of eyewear orders submitted to the processing lab. A restocking fee of 35% of usual customary charges for custom orders cancelled before completion of the product will be assessed. As eyewear is a custom made medical product, no refunds are available.

Contact Lens Policies

Contact lens services are a separate service from your eye exam. Should you wish to obtain a prescription for contact lenses, either a separate fitting or an evaluation of your current contact lens parameters is required to ensure the health of your eye. Contact lenses come in two forms, custom made and mass produced. Mass produced lenses may be returned for store credit if the boxes are unopened and in saleable condition (i.e. no markings). A restocking fee of 35% of usual customary charges for custom orders cancelled before completion of the product will be assessed. As custom made contact lenses are designed specifically for your eye no refunds are available.

To our patients with vision/medical benefits:

Medical insurance and vision plans are very different in their terms of service and their coverage. We are unable to determine which, if any, can be billed until after the examination is completed and the diagnosis for your primary complaint has been determined. It is your responsibility to know your coverage and co-pay amounts. Please be aware, unless your insurance plan has specific benefits for contact lens fittings, you will be expected to pay that amount along with your co-pay and any other non-covered services. Any out of pocket expenses collected from you at the time of service are ***estimates*** only, your insurance will determine your final out of pocket costs.

We will do our best to inform you of non-coverage prior to performing a service or ordering materials. In the event that your insurance company determines that you are not eligible at the time of service, or makes a determination that you are eligible for a reduced level of coverage, by signing this statement you are confirming your understanding that you are financially responsible for any and all charges incurred by you and not paid by your third-party plan. Be aware that any pre-authorizations received by our office are not a guarantee of payment from your insurance company. After we receive your plan's response, all remaining balances will be due within 30 days. If we do not receive a response from your insurance company within 90 days we will bill you for the balance due in full. Due to the timely filing restrictions imposed by many insurance companies, failure to supply us with the correct insurance information may result in payment in full being owed by you.

By signing below, you attest that this information was provided to you and that you understand your financial obligations.

Patient Signature (or Guardian, if under 18): _____ Date: _____

Guardian Name, if under 18 (Please Print): _____