Financial Responsibility Statement/Acknowledgement of Office Policies

Financial Policy

Payment is expected at the time service is rendered and before orders are placed. 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 $45. A cancellation fee of $125 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

The doctor will recheck your glasses prescription one time at no cost within 60 days of the date on which the prescription in question was determined. Should the prescription change be determined by the doctor to be caused for medical reasons the visit will be billed as a medical exam and your medical copays if applicable will apply. 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, a lens verification fee to confirm the correct fabrication of your glasses will apply prior to being scheduled with the doctor. This fee applies even if your glasses are found to be within tolerance. After 60 days, a fee will be incurred for any recheck as multiple factors can affect your prescription that are beyond the doctor's control. Rechecks will not be performed after 6 months from original exam date and a new exam will be necessary as too many factors can change within a short period of time that affect your prescription.

Eyewear and Low Vision Device Policies

This office will remake prescription glasses purchased from our office 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 be charged 50% of our usual and customary fees.

Glasses purchased from our office are covered by our No Hassle Warranty for up to one year from date of order placement. All warranty repairs and warranty replacement will be covered for a $50 copay per incident. This warranty does not cover lost or stolen eyewear.

If you wish to be reframed, you may do so once for a $50 administrative fee for frames of equal or lesser value within 60 days of the original order date. You may select a frame with a higher value and pay the difference in frame cost and the administrative fee. Reframing will count towards your first time warranty replacement option.

A $50 administrative fee will be charged for same day cancellations of eyewear orders submitted to the processing lab. As eyewear is a custom made medical product, no refunds are available. Eyewear orders not picked up after 90 days of initial notice are considered abandoned and will be dismantled and disposed.

Low vision devices and magnifier sales are final, no returns, exchanges or refunds.

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. Fitting fees are nonrefundable. 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 same day. Custom made contact lenses have special policies specific to each lens design and will be reviewed at the time of fitting.

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): _____