WELCOME to Select Eyecare - Loganville

Select Eyecare LLC

Financial Policy

1. **PAYMENT** for all professional services is due at the time services are provided.

2. **INSURANCE** companies do not pay 100% of all procedures. If you owe a balance after a claim is filed with your insurance company, a statement will be sent to you. Deductibles, co-payments, and non-covered benefits must be considered.

   IT IS THE RESPONSIBILITY OF THE PATIENT TO KNOW HIS/HER BENEFITS. IF INCORRECT OR EXPIRED INSURANCE INFORMATION IS PROVIDED, THE PATIENT WILL ASSUME FULL FINANCIAL RESPONSIBILITY.

3. **REFRACTION** is the process of determining the need for corrective eyeglasses or contact lenses and is necessary to write a prescription. Most medical insurance plans, including Medicare, do NOT cover routine refractions. The fee for a refraction is $35 and is collected at the time of service in addition to your medical plan co-payment. **If you have a separate vision plan or medical plan that provides an annual routine examination, the refraction is likely covered.**

4. **CONTACT LENS EVALUATION** is required annually of all patients who would like a prescription for contact lenses. The fee for the contact lens evaluation starts at $50 and goes up depending on fit complexity. This fee does not include the cost of the contact lenses and is non-refundable.

Contact lens prescriptions will not be given until a proper evaluation and follow-up appointment have been performed and all professional services are paid in full. A late follow-up fee of $30 will be charged sixty (60) days from the initial contact lens fitting examination.

Most insurance policies pay only a portion of your total charges. If you have any questions about your coverage, please contact your representative. We do not guarantee the accuracy of benefit information given to us by insurance companies. Please understand that financial responsibility for your account is yours, not the responsibility of your insurance company. I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical or vision benefits either to the physician or supplier of services rendered or to myself if the provider does not accept assignment. I understand that I am responsible for any balance my insurance does not pay.

By signing below, I acknowledge that I have read, understand, and accept this Financial Policy.

Name

Signature of Patient/Legal Guardian

Date

mm/dd/yyyy