# Vision without Limits Financial Policy

## Insurance Coverage

**The following financial policy applies to all patients who have insurance coverage.** Please carefully read and sign this agreement. Let our staff know if you have any questions.

1) We will be happy to bill your insurance company for your care providing you give us all the information we need. Even though you have insurance coverage, please remember that paying for your care is your personal responsibility.

2) You are required to pay your portion of the charges at the time of service. This includes the annual deductible, co-payment, and charges your insurance company refuses to pay. Our office policy does not allow us to extend credit.

3) We will need to verify your insurance benefits by contacting the insurance company.

4) We will bill your insurance company. Payment is expected within 60 days. We will automatically transfer and bill you for any payments not received from your insurance company after 60 days. You need to pay us in full at that time. Any amounts you personally owe that are 30 days late will receive a service charge of 1.5% per month, and if any further collection actions are needed you will be responsible for any collection fees.

5) Your insurance company may request additional information from you. Please send the information to them right away. They will not pay your claim until the receive the information.

6) Occasionally, an insurance company will send payment to a patient. If this occurs, bring us the check and the attached stub. The information on the stub is very important.

7) If you suspend or terminate your care against the advice of your doctor, all outstanding charges that have not been paid by you or your insurance company will become immediately due and payable by you personally before you leave.

8) MEDICARE PATIENTS: Please understand that you have a deductible that must be met yearly before Medicare starts paying for your visits. Then, after Medicare pays 80% of their approved fee, you will be responsible for your 20% co pay. We will gladly bill this co payment to your secondary insurance, but they may or may not pay for it. If they refuse to pay, the co-pay will be your responsibility.

By signing below you agree to follow this policy.

SIGNED:

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Patient or Guardian Date

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Print Name

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Finance Staff Date