OmniVision Eye Associates

FINANCIAL POLICY

Thank you for choosing OmniVision Eye Associates as your medical eyecare and vision care provider. We are committed to providing you and your family with the best available medical and vision care. In our ongoing process to make sure that all of your medical needs are met, our billing department will be available to discuss our fees and this policy with you.

We ask that all responsible parties read and sign our financial policy as well as complete the patient forms prior to seeing the Doctor.

Payments for all services will be due at the time services are rendered. In order to serve you better, we accept cash, check, Visa, Mastercard, Amex and Discover. As a courtesy to you, it is the policy of OmniVision Eye Associates to bill your insurance carrier, although you are ultimately responsible for the entire bill. As the responsible party, please understand:

(PLEASE INITIAL THE FOLLOWING)

_____1. Your insurance policy is a contract between you, your employer, and the insurance company . We are not a party to that contract. Our relationship is with you, not your insurance company. We will not become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, and secondary insurance charges. As your medical provider, we will only supply factual information to facilitate claim processing.

_____2. Fees for services, which include unpaid balances, deductibles and co-payments, are due at the time of service. Returned checks and unpaid balances may be subject to collection placement and/or service fees.

_____3. All charges are your responsibility whether your insurance company pays or does not pay. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. If any payment is made directly to you for services billed by Omnivision Eye Associates, you recognize an obligation to promptly remit payment to OmniVision Eye Associates.

_____4. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, after such default and upon referral to a collection agency or attorney by Omnivision Eye Associates, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

_____5. I understand that if I do not show for a scheduled appointment without giving 24 hours notice I am subject to a **$50.00** no show fee.

I UNDERSTAND THE ABOVE INFORMATION AND WILL BE RESPONSIBLE FOR THE PATIENT LISTED BELOW

Printed Name of Patient:_____ Date: _____

Signature of Patient/Responsible Party: _____