Vision Professionals

Financial Policy

Financial Policy and Third Party Policy:

There are two types of insurance that will help pay for your eye care services and products. You may have both

1. Vision care plans (such as VSP, EyeMed and Humana Vision)
   - Vision care plans only cover routine vision exams along with eyeglasses and/or contact lenses. They do not cover diagnosis, management or treatment of medical eye conditions.

2. Medical insurance (such as Aetna, Anthem, Cigna, Medical Mutual, Medicare and UHC)
   - Medical insurance must be used if you have any medical eye problem (dry eye, cataracts, glaucoma, floaters) or a systemic health problem that has ocular complications (diabetes, Hypertension, etc.). Your doctor will determine if these conditions apply to you.
   - If you have both types of insurance plans we will coordinate benefits for medical and vision to minimize your out-of-pocket expense.
   - We will bill your insurance plan for services if we are a participating provider for that plan. If some fees are not paid by your plan, we will bill you for any non-covered services. A doctor will discuss any non-covered services prior to administration.

Payments: Payment and/or co-payments for services are due in full on the day of service. Payment and/or co-payments for materials (frames, lenses, contact lenses, etc.) are due in full on the day the order is placed.

Returned Checks:

There is a fee of $35.00 for any checks returned by the bank.

Waiver of Confidentiality:

We will release your medical information in order to process third party claims on your behalf. If your account is submitted to an attorney, collections agency, court litigation occurs, or if you're past due status is reported to a credit reporting agency, prior medical treatment becomes a matter of public record.

I have read the above statement and agree to the content. In addition, I give my permission to Vision Professionals to provide any necessary Optometric services for myself and for any of my dependents. I understand that I will be financially responsible for non-covered services. In the course of my visit. I acknowledge the fact that my eye care provider will bill my insurance according to my eye care needs and diagnosis.

Patients Name:_____ Parent with Child:_____

Signature:_____ Date:_____