Eastern Eye Associates
OPTOMETRISTS

FINANCIAL POLICY

Our office provides a trained insurance coordinator to assist in filing your insurance. With your permission, we keep your signature on file to process your claims. Payment for services is needed at the time of service, unless prior arrangements have been made. **Full payment of your bill must be made in order to process your custom glasses or contact lens order.**

Your insurance policy is a contract between you and your insurance company. We cannot assume that any specific charge will be covered. Your involvement in knowing what your plan covers is important. This information is best obtained by calling the number on the back of your insurance card. When calling your carrier, you should verify your individual coverage and limitations, estimated out of pocket costs, verify that all criteria have been met to receive the service, and verify that the appropriate documentation and authorizations have been obtained prior to receiving services. You should also verify with your carrier that the provider you are seeing is considered an in-network or out-of-network provider. We are happy to provide you with any information you may need to complete this request.

All services, including but not limited to, co-payments, deductibles, and non-covered fees are the responsibility of the patient. All co-pays and deposits are collected at check out. All other balances will be subject to payment in full or monthly payment arrangements upon checkout. If your payment is made by check, there will be a fee of $35.00 per returned check, charged to your account, which is not covered by any insurance carrier. **By using a check for payment, you agree that in the event your check is dishonored or returned for any reason, you authorize us to electronically (or by paper draft) re-present the check to your bank account for collection of the amount of the check.**

Eastern Eye Associates (EEA) files primary and secondary insurance claims for our patients. In the event of a third insurance, claims are expected to be filed by the patient. If a service is considered “not covered” by your insurance company, the patient will be responsible for the charge. If you do not agree with the denial, you must resolve the matter with your insurance company. EEA will mail a monthly statement for any balances due. Payment is due upon receipt of your statement. After ninety days in default of payment, you agree to pay the collection fees as permitted by state law.

If, for any reason, you are unable to keep your appointment, please call our office to cancel at least 24 hours in advance. Failure to cancel an appointment without sufficient notice will result in a $25.00 charge to your account. This fee is not covered by any medical insurance. If you miss three or more appointments without calling to cancel in advance, you may be dismissed from the practice.

I have read and understand the practice’s financial policy and I agree to the terms.

_____ _____

Signature of Responsible Party Patient Name (Printed)

_____ _____

Date Patient Date of Birth