PRECISION
EYE CARE

PRACTICE POLICIES

Welcome to our office! *We thank you for selecting us to serve your needs. Our entire staff is a team dedicated to providing the highest quality eye health care and service to our patients. We take great pride in each staff member's training and capabilities. So we all can enjoy a smooth working relationship, we ask you to take a few minutes to read over our practice policies. If you have any questions, please do not hesitate to direct your questions to our Office Manager who will be most happy to address your concerns.*

Thank you, and once again, welcome!

REGULAR VISITS

Regular and follow-up preventive care is very important in maintaining long lasting eye health. Therefore, we encourage our patients to adhere to the recommended visits. We will advise you when it is time for your next visit and help you with appointments that best suit you and your busy schedule.

PAYMENT FOR SERVICES

Professional services are nonrefundable, and payment is due at time of service. We accept cash, Mastercard, Visa, Discover, American Express, Care Credit and personal checks. Bounced checks incur a $30.00 fee. Payment is due upon receipt and delinquent on the 15th day. Past due invoices may be sent to a collections agency. Patient agrees to pay all costs related to the collection of all sums including but not limited to legal fees and expenses.

APPOINTMENTS AND LATE CANCELLATIONS

Because we recognize that your time is valuable and we strive to minimize patient waiting time, we see our patients on an appointment basis (with the exception of emergencies – we will always squeeze in someone with a true medical emergency).

If you are not able to keep an appointment, please phone our office 24 hours in advance (or at your first opportunity). This will enable us to help you with another appointment and to fill your slot with another patient in need. Without 24 hours notice, a $25.00 booking charge may be billed to your account to reserve future appointments because it deprives other patients of the appointment slot that we reserved for you.

INSURANCE

As a courtesy to our patients, we take care of all insurance billing. All insurance must be verified prior to use, which is why we collected your information when you made your appointment. To use your benefits, please complete the authorization portion below:

I AUTHORIZE THE FOLLOWING:

1. Use of this form on all my insurance and/or union claim submissions.
2. The release of my information to my insurance companies and/or unions.
3. My insurance and/or union benefits to be paid directly to Precision Eye Care.
4. A copy of this authorization to be used in place of the original.

I understand that my insurance company will not guarantee quoted benefits. Should my insurance company pay differently than was expected at the time of my visit or should they take more than 45 days to issue payment, I will be responsible for any balance. Should Precision Eye Care receive excess payment, I will be refunded. I understand that the co-pay and deductible portions are due at the time of the appointment.

_____ _____

Patient Printed Name Date of Birth

_____ _____

Guardian/Patient Signature Date

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