FAMILY VISION CARE

Statement of Financial Policy

As a service to you, we accept several means of payment for the services and materials which you may require. *Payment of professional fees for examinations and office visits is due the same day the services are rendered. When eyewear is ordered, we ask that a 50% deposit be made at the time the materials are ordered with the remaining balance due upon delivery.* We file claims as a courtesy to our patients. The patient should know and understand the insurance, what it covers, copays amounts, and deductibles. The patient is ultimately responsible for the account balance. A finance charge of 1 ½% per month will be charged on outstanding account balances. *Payment arrangements can only be made prior to your evaluation.*

How will you settle your account today?

__ Cash or check	***__ Medicare***
__ Mastercard, VISA, Discover	***__ Medicaid***
__ Vision Service Plan (VSP)	***__ Blue Cross/Blue Shield***
__ Vision Care Plan (VCP) CompBenefits	***__ Tricare/Humana***
__ EyeMed	***__ United Health Care***
__ Spectera	***__ Avesis***
__ Other ________________________	***__ Coursourse***

I agree that all charges for services and materials are due and payable at the time of delivery as described above. Should my account become delinquent, I agree to pay all reasonable collection fees and court costs of collection. I understand there will be a $29.00 service charge on all returned checks. I have read and understand the above paragraphs.

X____ ______________________________

PATIENT OR RESPONSIBLE PARTY DATE

Extended Patient Signature Authorization

I hereby authorize my attending physician and consulting physicians to bill my insurance company direct for their service. I also authorize assignment of benefits to be sent directly to the physician. Futhermore, I understand that I am financially responsible to those physicians for charges not covered by my insurance company.

X____ ______________________________

BENEFICIARY OR PERSON SIGNING FOR BENEFICIARY DATE