EyeCare Associates LLC
Vision Source

Acknowledgement of Notice of Privacy Practices & Financial Policy

Copays

All copays are due at time of service, including those for VSP, Eyemed, and Medicaid. We will be unable to order your materials before these are paid and if there are outstanding copay balances we will be unable to see you for your exam.

Insurance

It's important to remember that insurance coverage and benefits vary significantly from plan to plan. To avoid surprises on your bill, it is important to understand what your insurance will cover.

As a courtesy to our patients, we are happy to submit your claims for services to insurance companies that we are providers for. In order for us to do this, you must provide us with accurate and up-to-date insurance information. If you find out you have coverage that was not provided to us before your exam or order, it will be your responsibility to pay us and seek reimbursement from your insurance company. If you find out you have coverage that was not provided to us before your exam or order, we will issue a refund after receiving payment from insurance.

All patients with a medical diagnosis [i.e. diabetes, glaucoma, macular degeneration, allergies, dry eyes, cataracts, etc.] may have their medical insurance billed prior to any vision care plan based on the providers discretion upon examination.

Any balance due after insurance has considered your claim will be your responsibility.

Payment Plan

If you are unable to pay, we ask that you apply for Care Credit, a patient financing company, designed to help with medical expenses. The plan is 0% interest for six months. If you are declined by Care Credit we offer a 3 month payment plan that requires at least a one-third payment before materials can be ordered.

Past Due Accounts

Past due accounts that have not received a payment in 2 billing cycles will receive a $15.00 finance charge that will be due along with any outstanding balance. If we still do not receive a payment or arrangements have not been made, we will turn your balance to a collection agency. This will negatively impact your credit history and will require you to prepay for all products and services in the future.

I have read and understand, acknowledge, and agree with the Privacy Practices & Financial Policy.

_____ _____

Signature of Patient/Guardian Date

I wish to share my medical information with (name & relationship) _____