Financial Policy/ Insurance Agreement

VISION INSURANCE:
Insurance: _____ Policy Holder:_____
ID #:_____

MEDICAL INSURANCE:
Insurance: _____ Policy Holder:_____
ID #:_____

PAYMENT POLICY: If we are a participating provider on your insurance company plan, any co-pay, overage, or any other balance not paid by your insurance *is required at the time of service.* Payment for any materials such as glasses or contacts is due upon receipt of those materials, a deposit is required upon ordering.

PLEASE HELP US HELP YOU! It is impossible for us to know every insurance company plan and contract. Therefore, each patient is responsible for understanding their own insurance policy. The insurance contract is between you and the insurance company NOT the physician and the insurance company. Our fees are not contingent up on insurance allowances or slow payment and the *patient is ultimately responsible to assure fee payment personally or the by the insurance company.* It is the necessary that you provide us with your most current insurance card so we may keep a copy of it on file. Without an insurance card we may be unable to file a claim. We will not re-file a claim if the information given to us was incorrect. When purchasing materials such as glasses or contact lenses we must have the correct insurance information when an order is being placed. If you are picking up materials and the proper insurance information was not given to us at the time of the order it is your responsibility to file the claim privately.

PLEASE BE SURE WE HAVE YOUR MOST CURRENT INFORMATION ON FILE. Do we need to update any changes in your name or contact information or insurance coverage?

The following ROUTINE insurances we are able to bill:
Aetna, Blue Cross, Cigna, EyeMed (Access & Basic), GreatWest, MVP, Spectera (EXAM ONLY), United HealthCare, VSP, Zenith Administrators, Medicaid and Tricare.

The following MEDICAL insurances are some that we are UNABLE to bill:
Banner Health, Kaiser, GreatWest, PVHC and Sloan's Lake

PLEASE NOTE: ***It is your responsibility to know if you are required to see a contracted provider.***

I have read the above information and agree to the conditions as outlined in regards to payment of fees for services rendered by Associates in Family Eyecare.

_____ _____

Signature *Date*