Associates in Family Eyecare

2249 W Eisenhower Blvd, Loveland, CO 80537 www.banfordstraub.com phone: 970.669.4587

Financial Policy/ Insurance Agreement

Please read carefully and ask any questions you may have after reading.

Please be sure we have your most current information on file. If you do not have physical copies of your card, electronic images can be emailed to **reception@banfordstraub.com**. We will not bill any insurance without either an image of a card on file or an electronic authorization.

PAYMENT POLICY

On the date of service: You are responsible for any copay designated by your insurance and any charges not covered by your insurance. Payment (at least half-down deposit) is required upon ordering glasses or contact lenses and full payment is required before dispensing.

We will assist you in verifying insurance, but ***each patient is responsible for understanding his/her own insurance policy.***

Our fees are not contingent upon insurance allowances or slow payment and ***you are ultimately responsible to assure fee payment personally or by the insurance company.***

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 the proper insurance information was not given to us at the time of the order, it will be your responsibility to file the claim privately.

The following insurances we are able to bill:

Medical: Aetna, Blue Cross Blue Shield PPO, Cigna, Medicaid, Medicare Part B, Tricare, United Healthcare

Vision: EyeMed, Medicaid, Vision Service Plan (VSP), Zenith Administrators

The following insurances we are unable to bill:

Blue Cross and Blue Shield HMO, CHP+, Kaiser, Spectera, GreatWest

****These lists are **not** comprehensive and may change. It is your responsibility to know if you are required to see a contracted provider.****

If you want us to bill a ***medical insurance for a routine vision exam***, these parts of the routine vision exam are not covered by your medical insurance and will be collected date of service in addition to any copays:

Refraction (to determine glasses prescription)	$44	☐ I Refuse this service
Contact Lens Fitting	Varies- $44 minimum	☐ I Refuse this service

I have read the above information and agree to the outlined conditions regarding payment of fees for services rendered at Associates in Family Eyecare. I request that payment of authorized benefits be made on my behalf to Associates in Family Eyecare for services rendered and authorize the release of medical information necessary to pay the claim.

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Printed Name

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Signature *Date*