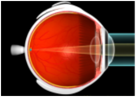

Insight Optometric Services PA

Patrick A. Patterson, OD

Financial Policies

1. Payment in full is required at time of services. We accept cash, checks and the following credit cards: Master Card and Visa, (American Express). . Our office may convert personal checks to Electronic Funds Transfer for payment. A $25.00 service charge will be added to any returned check or EFT.

2. All merchandise (Glasses and Contact Lenses) require a *50% non-refundable deposit*, the balance must be paid prior to dispensing. The merchandise must be picked up within 45 days of order.
(Sorry, because of problems in the past we can no longer make any exceptions to this rule.)

3. We are providers for many different insurance plans. Some are Vision Plans which only provide routine eye exams for glasses or contact lenses and some are Medical Insurance plans which cover medical oriented eye care such as infections or annual diabetic eye exams. Other plans may include both vision and medical benefits but have a different co-payment for specialist. It is important that you understand your own insurance plans benefits and limitations. If you have an insurance that we are not providers for we ask that you pay in advance and we will courtesy file your insurance for you.

4. Our goal is to verify your insurance benefits prior to service but this is not always possible. The patient or guardian is responsible for paying any co-payments or unmet deductibles at the time of service. We verify and file insurance at our own expense as a courtesy for our patients. We are willing to file a patient's primary insurance and one (1) secondary insurance claim. However, we must have all the necessary information at the time of the visit.

5. It is important to understand that you the patient are ultimately responsible for the bill if the insurance claim is denied. If your insurance claim is not paid within 90 days from the date of service we request that you pay your account in full and take the matter up with your insurance company. We verify and file insurance at our own expense as a courtesy for our patients.

6. For individuals who need financial assistance we offer three options: 1) Care Credit Application 2) Referral to NC Division Services for the Blind or to Local Lions Club Organization. 3) For patient who does not quality for assistance and who are denied by Care Credit we may provide patient with financial hardship payment agreement.

7. Optical Purchases – We pride ourselves on providing excellent care and quality eye wear. All prescription glasses are completely customized to the patient prescription and shape of the frame once the job has started it cannot be canceled and all sales are FINAL. Contact lens boxes that have been opened , written on, expired or otherwise altered cannot be returned for exchange or refunds.

8. Collection procedures: Once every month we will mail statements representing any balance due, including the amount your insurance company did not pay. Accounts that are 90 days old and have not been paid by the patient or the patient's insurance company will be considered delinquent and a final notice will be sent. If the patient fails to respond to this final notice we reserve the right to turn the account over to a collection agency or pursue legal action. The patient will be responsible for any collection fees and or attorney fees.

I allow the undersigned signature to be held on file for release of all protected health information, insurance billing claims, and/or telephone credit card payments made on my behalf.

MY SIGNATURE BELOW INDICATES THAT I HAVE READ, UNDERSTAND AND FULLY AGREE TO ABIDE BY ALL OF THE FINANCIAL AND OFFICE POLICIES OF BEAUFORT VISION. I hereby authorize direct payment through my insurance benefits to BEAUFORT VISION. I further understand and agree that I am personally and ultimately responsible to pay all charges incurred and that any insurance claims filed on my behalf are a courtesy, with no guarantee of final payment. I further authorize BEAUFORT VISION to release any medical or personal information as required for direct treatment, medical referral, or payment of insurance benefits, and agree to hold this office free of any or all liability related to the release of this information in accordance with HIPAA and federal law:

PATIENT NAME (Please Print) ____

SIGNATURE____ DATE_________________