



PAYMENT AND NON COVERED SERVICES POLICY

Please read over the following information very carefully before seeing our Doctors or Optician. We are attempting to eliminate any confusion about our payment policy. Please ask us if you are unsure!

- **PAYMENT IN FULL:** is expected at the time of service **UNLESS** you are on an insurance/Medicare plan that we participate in and your visit is a **COVERED** benefit. **PLEASE NOTE** many insurance companies **WILL NOT COVER ROUTINE SERVICES SUCH AS REFRACTIONS!!** Your visit must be for a medical condition. **REFRACTIONS** (test to determine if you need new eyeglasses) has a **SEPARATE CHARGE** and payment in full will be **EXPECTED TODAY.**
- **MEDICARE:** We accept Medicare assignment. We will also file your supplementary or secondary insurance for you. If your insurance company pays you direct for the 20% Medicare does not cover, you are responsible for the balance as well as any non-covered services. **MEDICARE DOES NOT COVER REFRACTIONS.**
- **HMO/PPO:** Plans that we are providers for; you are responsible for the **CO-PAY** stated on your insurance card plus any **non-covered** services. We cannot waive any **CO-PAY** due.



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- **PRIVATE/COMMERCIAL:** You are responsible for payment of any services rendered today except for surgical procedures. We will obtain prior authorization for surgical procedures. You will be provided with an itemized receipt to file to your insurance company.

I have read the above office policy completely. I understand and accept this policy. I intend to pay for Co-pay/non-covered services by (circle all that apply):

VISA MASTERCARD AMEX DEBIT CASH CHECK

Patient Signature: _____

Date: _____

Employee Witness: _____