

EAST DALLAS FAMILY EYE CARE

FINANCIAL POLICY

Thank you for choosing East Dallas Family Eye Care to serve you and your family’s eye healthcare needs. Your vision and/or medical insurance is a contract between you and your insurance company. We can often help with providing information to help you in filing claims, but you are primarily responsible for any charges that you have incurred as a patient with East Dallas Family Eye Care

Please review and sign the following financial policy prior to your visit:

- 1) CO-PAYMENTS, DEDUCTIBLES, AND FEES – **All co-payments, insurance deductibles, and fees for services not covered by your insurance are due at the time services are rendered.** We accept cash, checks, or credit cards (VISA, MasterCard, American Express, Discover). Outstanding payments are due at the time of service unless other arrangements have been made.
- 2) INSURANCE – You must present a current insurance card at each visit. If you or your children do not present a current insurance card, there are two options:
 - a) Your appointment must be rescheduled to a time when you can bring the insurance card to us.
 - b) If you need to be seen right away, we have to collect for the visit. In such instances, we cannot refund your money to submit the visit to your insurance carrier.

If your insurance carrier is not one with which we participate, you are responsible for payment in full. Insurance plans and Medicare consider some services to be “non-covered,” in which case you are responsible for payment in full. You are responsible for providing information to our clinic so a claim can be properly submitted. **If your insurance company has not paid a claim on your behalf in 90 days because of information you have not provided, the balance will be transferred to your account and you will be responsible for payment.** If we receive payment at a later date, you will be reimbursed.

- 3) MISSED APPOINTMENTS – **Unless they are cancelled by 4:00 pm the previous business day, our policy is to charge for missed appointments.** The fee for a missed appointment is \$25. This fee is not covered under your insurance plan and is your responsibility. If you no-show three consecutive times, you will be dismissed from our practice.
- 4) PROMPT PAYMENT – Just as we make every effort to accommodate you when you are in need of eye health care, we expect that you will make every effort to pay your bill promptly. If you have financial hardship or if you are unable to pay your bill in its entirety, please contact our billing office to discuss payment options. If your account becomes delinquent and you have not established or met your payment options with our billing office, your account will be turned over to a collection agency, and we will ask you to see your medical care from another eye health care practice.

I have read the financial policy and agree to its terms

Patient or Guardian Signature: _____

Date: _____