

VALLEY FORGE EYE CARE: FINANCIAL POLICY

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE

Payment is required at the time of services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance and copayments for participating insurance companies. **Valley Forge Eye Care** accepts cash, personal checks (in-state only), VISA, MasterCard, and American Express. We accept most **HSA and FSA** credit and debit cards for payment of exams, glasses and contact lenses. Your time of service receipt includes all information necessary for submitting expenses to your HSA administrator. There is a \$25 service charge for returned checks.

INSURANCE:

We bill participating insurance companies as a courtesy to you. You are expected to pay your deductible and copayments at the time of service. If we have not received payment from your insurance company within 45 days of the date of service, you are expected to pay the balance in full. You are responsible to be sure all charges are paid whether by you or by your insurance carrier.

If you are enrolled in a managed care insurance plan (i.e. HMO), you **must receive a referral** from your PCP office before seeing Dr. Burgess. Retroactive referrals are not guaranteed.

Refunds / Credits:

Payments collected at the time of service are **estimates** based on the information provided to us by you and your insurance provider. Refunds will be processed by the original payment method. **We are doing everything possible to hold down the cost of medical care. You can help a great deal by reducing the number of bills we send to you. By initialing below you authorize us to charge the credit card token on file for charges the insurance company deems as your responsibility under \$25.**

(initial) ☐ **YES**, you have permission to charge my credit card on file for balances under \$25 (Statements will be emailed)

(Initial) ☐ **No**, please send me a statement by mail.

Patients with an outstanding balance 60 days or more overdue must make arrangements for payment prior to scheduling appointments.

Eyewear orders are custom made and qualify as final sale. Open boxes of contact lenses are **non refundable**

I have **read and understand** the Valley Forge Eye Care Financial Policy. I agree to assign insurance benefits to Valley Forge Eye Care whenever necessary. I also agree if it becomes necessary to pay the fee charged by the collection agency for costs of collections.

Signature of insured (or Representative): _____ **Date:** _____

HIPAA Acknowledgement

I have read/received a copy of Valley Forge Eye Care's **NOTICE OF PRIVACY PRACTICES**

Patient Name (Printed): _____

Patient Signature: _____ **Date:** _____