Valley Forge Eye Care: Financial Policy

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. The following is a summary of our payment 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. There is a service charge for returned checks.

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

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 may be 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.

HEALTH SAVING ACCOUNTS (HSA, FSA)

We accept most HSA 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.

REFUNDS:

Patient/guarantor credits in amounts of $40.00 or less will be retained on account to be credited toward future balances unless a written request for a refund is received. Amounts greater than $40 will be refunded to the patient/guarantor.

MANAGED CARE:

If you 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.

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 that 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: _____