FRANK EYE CENTER FINANCIAL POLICY 2024

Patient Name _____ **Date of Birth** _____

Insurance Coverage: It is your responsibility to provide our office with accurate information for billing your insurance at the time of service. It is also your responsibility to know if your visit is covered by your primary insurance plan fully, partially, or not at all. For example, you may be covered under your primary healthcare plan and for additional vision services under a different carrier. It is your responsibility to know if you have separate coverage. If, at time of service, you do not provide us with your current coverage and late make us aware of additional coverage you will be responsible for any and all charges. We will gladly provide you with an itemized receipt to submit to your insurance for reimbursement. Information of this type is only 100% accurate if you obtain it directly from your health plan. In the event you do not confirm this information and the insurer refuses full or partial payment, you will be responsible for the cost of services provided.

Medical Insurance Information:

Primary _____
Insurance **Name of Insured** **Insured Date of Birth**

Secondary _____
Insurance **Name of Insured** **Insured Date of Birth**

Vision _____
Insurance **Name of Insured** **Insured Date of Birth**

Glasses and Contact Lens Exams
Exams for glasses and contact lens are separate exams. If you desire both exams on your visit, you will be charged a contact lens fitting fee of $45.00. Contact lens fitting fees may not be covered under your insurance plan. We require this fee to be paid at the time of service.

Amounts Due from Patient
Insurance co-payments will be collected at the time of service. If we do not participate with your insurance plan, you are to provide full payment at the time of service. If you are using insurance, we will make every effort to collect full and accurate fees specific to your plan. However, if there is a fee that your insurance charges and we did not collect it at the time the order was placed it must be paid in full before the glasses or contacts will be dispensed.

Amounts Determined "Not Covered"
In the event a health plan determines a service to be "not covered", you will be responsible for the complete charge. An example of this is the refraction. A refraction is a test to obtain your best corrected vision, to determine the need for glasses, surgery, and/or medicine. Most medical insurance plans, including Medicare, do not cover refractions. Our office will collect the refraction fee of $35.00 and any co-payments at time of service.

I have read and understand the financial policies of Frank Eye Center.

_____ _____
Signature of Patient (or responsible party) **Date**