Optix Eye Care Financial Policy
Please Read Carefully - Complete and sign with legal name

It is our goal to maximize your **eye health benefits** as effectively as possible. So that we do not miss important information regarding your **eye health benefits**, we ask that you present a valid insurance card at every visit.

Self Pay: Payment is required at the time of service. We do not offer in-office credit or payment plans of any type. We do accept Care Credit and will be happy to assist you with the application process should you be interested in this option.

Participating Commercial Insurance: As a courtesy, we file most insurance carriers for you. We must have both your health and vision plan insurance information. **Copay and deductible amounts are due and payable at the time services are rendered.** If your insurance carrier has not paid within 30 days of billing, we will make every effort to resolve the matter and re-file if appropriate. However, if we are unable to reach resolution with your insurance carrier within a reasonable time frame, fees will be due and payable in full from you.

Non-Participating: We will also file claims to non-participating health insurance carriers. However, we require payment **in full** at the time of service from patients whose insurance is considered out of network. Any payable benefits will be reimbursed directly to you after the claim is filed and payment received by our office.

Outstanding Balance: Any **outstanding balance** is due **prior** to checking in for your appointment.

Medicare: Optix Eye Care is a participating provider and we will file claims to Medicare for you. If you have a secondary insurance, we will file it for you as well. In the event that you do not have secondary insurance, you will be responsible for paying any deductible and 20% coinsurance amounts. Furthermore, Medicare does not cover refractive or routine vision services, it is your responsibility to pay for these services in full.

Medicaid: Optix is a participating provider and we will bill Medicaid for you. You must present a **valid insurance card** at each office visit. Please note, Medicaid will cover routine vision services and glasses for patients who are under 21 years of age every **12 months** and patients who are 21 years of age or older every **24 months**.

Glasses and Contact Lenses: Balances on glasses must be paid in full **BEFORE** dispensing, there will be **NO** exceptions to this. **Cancellation of an order that has already been placed for any custom made optical item (ie: prescription glasses, prescription or custom sunglasses, custom clips, etc) will result in a 20% restocking fee**. Contact lenses must be paid in full **before** ordering.

Notice to parents or legal guardians of minor children: It is the business practice of Kim Walters, OD, PA, (dba Optix Eye Care) to seek payment in full from the guarantor listed on the account of a minor patient. We will not involve our business in **any** "financial arrangement" made between parents or legal guardians. Payment in full is **required** at the time services are rendered and at the time glasses or contacts are dispensed. There will be **NO** exceptions to this practice.

Accepted methods of Payment: Cash, personal check (with proper ID), debit/credit cards (Visa, M/C, AmEx, Discover) & Care Credit.

Returned checks: Will assess a $25.00 return check fee as well as any applicable bank fees. Checks that are not paid within 2 weeks of being returned to our office will be reported to our check collection service.

Collections: Balances **not paid** according to the above terms will be reported to an outside collection agency. In the event that your account is turned over to collections, you agree to pay all additional fees assessed in the collection of the debt.

I the patient or guarantor have read, understand and agree to the above financial policy for payment of professional services and hardware. I further understand I am the responsible party regarding all financial matters and I am ultimately responsible for all balances owed.

Patient printed Name: _____ Date of Birth: _____

Patient, Parent or Legal Guardian Signature:_____ Date:_____