Children's Eye Center
Payment Policy

Self Pay and Non-Insurance
For private pay or non-insurance patients, payment in full is expected at the time of service.

Insurance
All professional services rendered are charged to the patient, with the exception of plans for which we are a participating provider. In the latter case, we will bill your insurance company and only the patient portion of the visit is payable at the time of service. This includes all applicable copays, deductible or non-covered services. *If current and / or correct insurance information, including referrals / authorizations are not provided and the insurance carrier refuses payment, you will be billed for the visit. If we are not contracted with your insurance carrier you will be billed for the visit. If your insurance denies payment for the service, you will be billed for the visit.* **It is your responsibility to know what your insurance covers.**

Refraction
This is a part of the eye exam that is performed to determine if the patient either needs correction (i.e. glasses or contacts) or if they need a change in an existing prescription. The refraction is also used to aid in the medical decision making of most eye problems and is performed on the majority of our patients from time to time. The refraction is not always covered by insurance plans we are contracted with. *If your insurance company denies payment for this service it will become your responsibility.* Your signature below signifies your understanding of this policy.

Signature__________________________________ Date __________________

Divorced Parents
In cases of divorced parents, the parent bringing the child to the visits will be deemed responsible for payment. Our office cannot become involved in custody disputes over which parent is the responsible billing party.

Billing
We will send you a statement in the mail if you owe a portion of the charge that was not collected at or prior to the time of service. If payment IN FULL is not received by the due date listed on your statement, a statement charge of $10.00 will be added to your account. In some instances we will agree to a short term payment arrangement. In these cases the statement fee will be reduced to $5.00 per month. If the balance goes unpaid or if we are unable to contact you regarding the balance we will turn your account over to our collection agency. If we are forced to do this a $25.00 collection fee will be added to the unpaid balance on the account. Likewise, there is a $25.00 service charge on all returned checks.

Missed Visits
Because everyone's time is valuable, we request 24-hours notice for cancellations. Patient's who do not cancel their appointment 24 hours before and/or miss their appointment will be charged $25.00 and $100.00 for a missed surgical procedure.

Test Results ("X" one or all if desired)
_________ We may leave test results at phone #: ______________________________________
_________ We may leave test results on you answering machine.
_________ We may leave a message for you to call Children's Eye Center to get your results.

I, the undersigned, hereby agree to be financially responsible for fees incurred, authorize the release of any medical information necessary to process the claim, and request payment of insurance benefits including Medicaid and other government sponsored programs, to Children's Eye Center.

I, hereby grant authority to Children's Eye Center to perform an eye examination including test necessary to the diagnosis and treatment of this patient.

If you understand and agree to follow the above stated policies, listed on this page, kindly sign below, Thank you.

Signature__________________________________ Date ______________________________

Printed name of Signature above_____________________________ Patient's Printed Name: ____