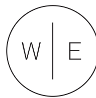

WESTLAKE EYECARE

Financial Policy

- Refraction is a test used to determine the patient's spectacle prescription. Some insurance companies do not cover the cost of refraction, currently set at $60, and patients will be billed this amount upon denial from their insurance carrier. Medicare does NOT cover refraction; patients with Medicare will be required to pay this fee at the time of service.
- As a courtesy to our patients, our office will file insurance claims for Westlake Eyecare PLLC providers with participating insurance carriers and vision plans. However, Westlake Eyecare PLLC does not participate with all plans. Each patient is responsible for verification of their coverage. We will be happy to assist you on a limited basis with your authorization process but we encourage you to familiarize yourself with the specifics of your plan prior to your visit, particularly pertaining to co-pays, deductibles, routine eye coverage, etc.
- If we do not file insurance for your services, we will provide a receipt so that you are able to file for personal reimbursement, if any.
- HMO insurance policies require a referral from the primary care physician, which the patient is responsible for obtaining that referral prior to the visit.
- Patient authorizes the release of any information concerning health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
- Patient authorizes payment of insurance benefits payable directly to the doctor.
- Any outstanding balances more than 120 days will be forwarded to our collection agency unless payment arrangements have been made with our Billing manager. You will be responsible for all fees charged by the collection agency.

Please read, initial and sign below:

(Initial) __________ **FINANCIAL RESPONSIBILITY:** I understand that I am responsible for any charges not covered by my insurance, including co-pay, co-insurance and deductible payments. Payment is due at the time of service. I understand that I am responsible for any authorization or referral my insurance may require, prior to the time of service. I understand that I am ultimately responsible for payment on my account.

(Initial) __________ **INSURANCE COVERAGE:** I understand that it is my responsibility to update Westlake Eyecare with current, accurate insurance information at each visit. I will be responsible for any balance due as a result of not disclosing this information.

(Initial) __________ **FEE FOR MISSED APPOINTMENTS:** I understand that there is a $40.00 fee for missing a scheduled appointment. This fee is not covered by insurance. Westlake Eyecare PLLC requires a 24-hour notice for appointment cancellations.

(Initial) __________ **ALL SALES FINAL:** I understand that all contact lens, frame and lens sales are final and unless defective will not be accepted for return.

____ ________________________

Patient/Guarantor Signature **Date**

Questions or concerns should be directed to our billing department

www.WestlakeEyecare.com