EyeCare Associates Optometric Group

FINANCIAL POLICY

Thank you for choosing us as your eyecare provider. We are committed to providing you with the finest quality service and materials available. In order to accomplish this, we need you to understand your financial responsibility. The following is a statement of our Financial Policy which we require that you read and sign prior to any service.
All Patients must complete our information and insurance form before seeing the doctor.

- FULL PAYMENT IS DUE AT THE TIME OF SERVICE
- WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS AND CARE CREDIT
- A MINIMUM 50% DEPOSIT IS REQUIRED ON ALL CUSTOM EYE WEAR

Regarding Insurance

Unless we are on a particular insurance panel, we do not accept assignment (payment) of insurance benefits. However, we will submit paperwork to your insurance company on your behalf, provided that the bill is paid in full. We cannot bill your insurance company unless you bring in all insurance information and/or an original claim form. Please note that your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Also, please be aware that some and perhaps all of the service provided may be noncovered and not considered reasonable and necessary under your particular insurance program.

Usual and Customary Rates

Our practice is committed to providing the finest service available. We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary fees.

Missed Appointments

Unless canceled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping your schedules appointments.

Eyewear Warranty

Frames: All frames purchased at our office will come with a one-year defect/breakage warranty. All breakages must be normal wear and tear (glue, chewed, or frame abuse will invalidate warranty). We will either repair or replace your frame with the same frame at no charge (all parts of broken frame must be presented at time of return).

Lenses (SV/BF/Progressive): We will verify your prescription. If you are having a problem with your new prescription, please come into the optical center within 30 days. If we are unable to find a solution we will schedule you to see the doctor again for a reevaluation. Any prescription changes made by the doctor within 90 days of the eye exam will be done at no charge. All lenses purchased have a one-year defect warranty (i.e. scratch resistance, lens coatings, anti-glare coatings, etc. under normal wear and tear) if purchased with an anti-reflective coating. We will replace the lenses at no charge. Eyewear is custom made, based on the prescription written for each patient. Since these are special order lenses, we are unable to offer any refunds.

Reusing Existing Frames: Due to the age of an existing frame they may crack or break when new lenses are inserted, therefore we cannot be responsible for any damages or loss to the frame as they are being reused at your request. In the event that the frame breaks during the process, we will make a replacement frame available to you at 35% off the normal retail price.

Return Policy: Frames must be in perfect resale condition. We are unable to offer cash refunds. Non-defective frame products that are returned will be charged a 20% restocking fee.

I have read the above Financial Policy. I understand and agree with its terms.

X_____ Date: ____ /____ /_____

RELEASE AND ASSIGNMENT

Date: _____ /_____ /_____

To:_____(Insurance Company)

I hereby authorize Dr. Michael C. Morris and/or Dr. Thear Bun to release to your company or its representative, any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Medical care. I also authorize and request your company to pay directly to the above name doctor the amount due in my pending claim for basic Medical and/or Major Medical treatment or services, by reason of such treatment or services rendered to:

_____ _____

(Patient Name) (Signature of Insured)