BLUE VISION CENTER

Financial Responsibly Acknowledgment

I acknowledged I have insurance and assign directly to Blue Vision Center all medical and/or vision plan benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

- Payment for professional services (eye examinations, specialty testing, office visits) is due the day services are provided. Payment for eyeglasses and contact lenses is due in full the day materials are ordered. All sales are rendered final at the time of purchase and no refunds will be allowed. Exchanges for eyewear or contact lenses maybe honored as needed. Due to optical orders being custom, if a refund is honored a 25% restocking fee will apply. For your convenience, we accept cash, checks, Sunbit, Care Credit, debit cards, and credit cards: Visa, MasterCard, American Express.
- We are providers for a wide array of insurance plans and are happy to file those claims on your behalf. Payments for copayments, deductibles, and items known not to be covered by your insurance are expected at the time of your visit**. You are also ultimately responsible for all charges for which your insurance company denies payment when we receive your *Explanation of Benefits* statement from them. Blue Vision Center will verify your insurance with the information you provide, if the insurance company gives the incorrect information, ultimately you are responsible for all charges.** We ask patients with insurance for which we are not providers to make payment in full when services are rendered. If applicable, an itemized statement that can be submitted to your insurance company for reimbursement will be given to you at the time of your visit.
- For those with flex spending accounts, payment in full for services rendered and materials ordered is expected. An itemized statement that can be submitted to your insurance company for reimbursement, will be given to you at the time of your visit.
- If payment from the insurance company has not been received in 60 days, you will be responsible for paying your account balance in full.
- Finance charges at the rate of 1.5% / month (18% APR) will accrue on all outstanding balances over 90 days
- In some families, the question of who is responsible for a child's bill is uncertain. Since we are not privy to any separation agreement or court order, this is strictly a matter between parents. We must insist, therefore, that the parent who requests evaluation and treatment for the child will be responsible for all fees incurred.
- A service charge of $30.00 will be applicable for all checks returned for any reason, including insufficient funds and stop payments. For any amount over $300.00, a service charge of 10% will be charged. If our office is required to take legal action to collect any unpaid charges, you will be billed the cost of attorney fees, court costs, and collection fees in addition to any unpaid balance.
- **If a balance is not collected by the final notice, the office will send your account to collections and you will be charged a $150 charge on top of the balance owed if the balance is not paid in full before that time.**

Patient Signature	Date
Witness Signature	Date