EVANS FARM FAMILY EYE CARE FINANCIAL POLICY

Thank you for choosing Evans Farm Family Eye Care, LLC as your health care provider. We are committed to building a successful relationship between our doctors and patients. Your clear understanding of our Financial Policy is a part of that professional relationship. We encourage you to ask if you have any questions about our fees, our policies, your responsibilities for payment or your responsibility to notify our office of any patient information changes

(i.e. address, name, insurance information, etc.).

INSURANCE INFORMATION AND PAYMENT

Presentation of your health insurance card at each visit- It is necessary for us to verify your demographic and insurance information at each visit. You must present your card at each visit. Inaccurate information prevents us from billing your insurance and results in much wasted effort by our billing staff. Therefore, if you forget your insurance card or we are unable to verify your coverage, it may be necessary to reschedule your appointment or pay in full at the time of service.

Insurance Claims- We will bill your primary insurance company and secondary insurance as a courtesy to you. In order to properly bill your insurance company, we require that you disclose all insurance information, including primary and secondary insurance, as well as any change in your insurance information. Failure to provide complete insurance information may result in you being responsible for the entire bill. Although we can estimate what your insurance company may pay, the insurance company makes the final determination of your eligibility and benefits. You will be responsible to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment.

Payment- We accept cash, check, Visa, MasterCard, Care Credit, AND HSA cards. A $30.00 returned check fee will be assessed for any returned checks.

50% down payment is required to order glasses and 100% down payment for contact lenses. The balance is due when they are dispensed.

Insurance Co-payments- If your insurance plan requires a co-payment, you are expected to pay this at the time of service.

Collections- Accounts with services over 60 days old are considered "Past Due." Our billing staff will make a reasonable attempt to notify you if your account has reached a "Past Due" status. It is important that all changes in your name, address, phone number, insurance, or employment be relayed to our office as it can affect the billing of your account. If we are unable to locate a patient, payment is not received, or satisfactory payment arrangements are not made, then an account will be referred to our collection agency. Should this occur the patient will be responsible for collection fees and expenses.

RETURN POLICY FOR EYEWEAR & CONTACT LENSES

Eyeglasses are custom-made for you and you only, so there are **no returns or exchanges for any purchased eyewear** (including lenses and frames). Even though all sales of prescription and non-prescription eyeglasses and sunglasses are final, patients are welcome to return to the office ***as many times as needed*** before the decision to purchase is made. If there is a need for the prescription to be adjusted, such changes are included at **no charge** for a **one-time redo** within **90 days**. If there are any discrepancies between the doctor's prescription and the lenses manufactured by the lab, these changes will be provided at **no charge**. All of our lenses & frames have a warranty for any manufacturer defects for up to one year from the date of purchase.

Even though the eyeglass frame is under warranty by the manufacturer, the manufacturer does not pay for the shipping and handling for the exchange of the defective frames for the new frames. The patient will be responsible for the two-way shipping and handling costs involved **($20.00).** There is a shipping and handling charge for the lens warranty as well **($10.00).**

With regard to the sale of **non-specialty** soft contact lenses, any **unopened & unmarked boxes** may be returned for a full refund, or exchanged, within 3 months if there has been a change to your prescription. However, all sales of specialty gas permeable (i.e. rigid) and hybrid (i.e. containing both rigid and soft components) contact lenses are final. During the trial period in determining the proper prescription for such specialty lenses, any exchanges or returns will be granted at no charge so long as enough time is given for the lenses to be mailed back to the manufacturer, in order to meet the manufacturer's 90-day exchange/return policy.

NO SHOWS AND FEES:

We take many measures to help ensure you know when you are scheduled for your appointment. We send numerous text messages as well as call the day before to remind. Due to the back-end cost of a missed appointment, we have reserved the right to refuse scheduling patients after they have no-showed to 2 appointments. After 2 no-shows, we may require a $10 fee to be paid upfront before we put you back on our schedule. That will be at the discretion of the doctor.

Lack of Cooperation

We are grateful for all of our patients and the opportunity to serve them. We appreciate your assistance in helping us complete our work in an efficient and accurate manner. We believe that all patients should be treated with dignity. We reserve the right to terminate a patient from the practice in those rare cases when a patient may be verbally or physically abusive, refuse to give necessary information, or is non-compliant with ocular instructions, treatment and advice.

This financial policy helps the office provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact us.

By signing this form, I agree that I have read the financial policy and agree to the terms. I agree for all payments from my insurance carrier to be made directly to Evans Farm Family Eye Care, LLC. I certify that the information I reported with regard to my insurance coverage is correct. Evans Farm Family Eye Care, LLC may share the results of today's examination with my insurance company, if necessary, to ensure proper processing of the claim.

Print Name: _____

Patient/Guardian Signature: _____Date:_____