Columbia Falls Eye Care

Account Policy and Insurance Authorization

Please take a moment to familiarize yourself with our account policy. We are committed to providing you with the best possible eye care. In order to meet this objective and to help our office run as efficiently as possible, we must strictly adhere to our account policy as described below.

PAYMENT FOR DOCTOR SERVICES IS DUE IN FULL AT THE TIME OF SERVICE

Columbia Falls Eye Care accepts cash, personal check, money order, all major credit cards and Care Credit. There is a $30 service charge for any returned check. For those with verified insurance coverage, the estimated patient responsibility for services rendered, including copays, is due at the time of service.

EYEGLASSES

Payment is due in full for all glasses at the time of the order. For those with verified insurance coverage, the estimated patient responsibility for glasses is due at the time of pick up. We reserve the right to balance-bill the patient if insurance payment is less than anticipated. It is your responsibility to discuss any special payment arrangements PRIOR to your order. Cancellation of any material orders after the order has been placed is prohibited. All material orders have a patient satisfaction guarantee on frames, lens design/features and Rx, which expires 90 days after the order is processed. Exchanges may be subject to a restocking fee of $35.

CONTACT LENSES

Columbia Falls Eye Care utilizes direct-to-you delivery on soft contact lens orders. Payment is due in full for all contact lens orders at the time of the order. Those with verified insurance coverage for contact lenses are responsible for their estimated out-of-pocket expenses, including copays, at the time of the contact lens order. We reserve the right to balance-bill the patient if insurance payment is less than anticipated. Cancellation of any material orders after the order has been placed is prohibited. All contact lens orders have a patient satisfaction guarantee on lens design/features and Rx, which expires 90 days after the order is processed. Returns and/or exchanges are available on unopened boxes only and may be subject to a restocking fee of $35.

ACCOUNT RESPONSIBILITY

You are ultimately responsible for all charges incurred. We bill participating insurance companies as a courtesy to you. However, your insurance is a contract between you and your insurer. If we have not received payment from your insurance company within 60 days of date of service, you will be expected to pay the balance in full. Unpaid balances are billed monthly. Any balance that remains unpaid after 90 days will be sent to our collection agency, regardless if materials have been picked up, and a 30% collection fee will be applied to your balance.

INSURANCE

There are two types of health insurance that may help pay for your eye care services & materials. You may have and our practice accepts both:

1. Vision care plans (such as VSP and Eyemed)
2. Medical Insurance (such as Blue Cross Blue Shield and Medicare)
    - Vision care plans typically cover only routine vision exams, along with eyeglasses and contact lenses. Vision plans cover only a basic screening for eye disease. They do not cover diagnosis, management or treatment of eye diseases.
    - Medical insurance must be used if you have any eye health problems of a systemic health problem that has ocular complications. Your doctor will determine if these conditions apply to you, but some are determined by your case history.
    - If you have both types of insurance it may be necessary to bill some services to one plan and other services to the other. We will use coordination of benefits whenever possible to do this correctly and minimize your out of pocket expense.
    - We will bill your insurance plan for services if we are a participating provider for that plan. We will try to obtain advance authorization of your insurance benefits in order to inform you of what is covered. If some fees are not paid by your plan, we will bill you for any unpaid deductibles, copays and non-covered services as allowed by the insurance contract

ASSIGNMENT OF BENEFITS & ACCOUNT POLICY AGREEMENT

I have read and understand the Columbia Falls Eye Care Account Policy. I agree to assign insurance benefits on my behalf to Columbia Falls Eye Care whenever necessary. I understand that I am fully responsible for any penalties, service charges and handling fees. I also understand that nominal adjustments may be made to this policy in the future without my knowledge. Furthermore, I agree that if it becomes necessary to forward my account to a collection agency, that in addition to the amount owed I will also be responsible for any fees charged by the collection agency for costs of collection and/or litigation.

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Printed name of Insured/Authorized Representative Signature of Insured/Authorized Representative

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Date