PASCO VISION CLINIC FINANCIAL POLICIES

Thank you for choosing Pasco Vision Clinic, PS as your eye care provider. The following is a statement of our Financial Policy. If you have any questions please feel free to ask our staff.

INSURANCE

We do not guarantee the accuracy of benefit information given to us by insurance companies. Any insurance benefit quote we are given is not a guarantee of payment. I understand that payment for all services and materials are the ultimate responsibility of the patient and that I will be required to pay any balance left unpaid by my insurance after 60 days from the date of service.

_____(Please initial)

Most insurance policies pay only a portion of your total charges. If an insurance plan is involved, your co-payment and/or the difference between your fee and your coverage must be paid at the time of service. If we are not able to verify your insurance coverage or eligibility on the date of service or if your plan requires special forms that you have not provided on the date of service, we will ask you to pay privately for your services and seek reimbursement from that plan.

MATERIALS

Our practice is committed to providing the finest eyewear products available. We have products available in a wide range of prices. Most eyewear products are custom made for your use. We require payment in full for your eyewear and contact lens purchases, payment is due at time of service. We welcome telephone orders secured by your credit card.

CONTACT LENSES

Please be aware there is an additional charge for the fitting and continued care of contact lenses. This fee includes the doctor doing an additional contact lens exam; a valid contact lens prescription; trial lenses and any follow-up with our contact specialist.

CANCELATION POLICY

Each time a patient misses an appointment without proper notice, another patient is prevented from receiving care.
Our staff will make every effort to verify appointments by phone, email, and/or text message 48 hours before your scheduled appointment. Therefore, it is necessary for you to notify our office within 24 hours of the intent to cancel or reschedule an appointment. **A charge of $55 per appointment will be assessed to you if you do not cancel or reschedule within that 24 hour time frame.** Please note, this same charge applies if you miss a scheduled appointment without notifying us.

By reading and signing this document I give consent to and authorize the performance of any treatments, examinations, medications or medical services as ordered or approved by my attending physician. I also acknowledge that Pasco Vision Clinic, P.S. or its agents may use all available phone numbers, addresses or email address to contact the patient for follow-up appointments or to further conduct its business.

Thank you for your cooperation and understanding in this matter. We look forward to providing you with the best care possible.

☐ **YES** ☐ **NO** **I give my consent to Pasco Vision Clinic to verify my medication history.**

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Patient Signature (or Parent/Guardian) Date Signed Rev. 07/2017