

# Claremont Optometry Group

## Financial Policy and Privacy Policy Acknowledgement

The doctors and staff are committed to providing you with thorough, professional eye care. If you have medical insurance that covers eye care or other vision insurance, we will be glad to complete any forms you may have and assist you in obtaining your maximum allowable benefits.

Payment for services is due at the time the services are rendered unless other payment arrangements have been made and approved by our staff. This includes services provided for a minor patient. The presenting parent is responsible. We prefer payment in full when ordering glasses or contacts. However, a deposit of 50% can be made to initiate the order. The remaining balance will be due at dispensing. We accept cash, checks, Visa and MasterCard.

We are panel providers and accept assignment on several vision plans and Medicare. This means that at the time of the exam, you will be responsible for any co-payments, deductibles or fees for non-covered services. We will bill and receive payment directly from your insurance company for covered services. You will be responsible for any remaining balance. **Please ask a staff member if we are panel providers and accept assignment for your plan prior to your examination.**

If you need a referral from your primary provider to see us, it is your responsibility to obtain that referral prior to your examination. A referral with an authorization number is not a promise to pay for that visit. If for some reason you were not eligible for services at the time of the examination, your HMO, PPO or IPA may deny payment and you will still be responsible. Please realize that: 1.) Your insurance coverage is a contract between you and your insurance company. 2.) Our fees for covered services normally fall within acceptable ranges set by most insurance companies and are usually covered up to the maximum allowance set by each carrier. If this is not the case, the patient is still liable for the remaining balance. 3) Not all services are a covered benefit in all contracts and routine eyecare and other selected procedures may be specifically excluded, making the patient responsible for the charges. We will try to furnish you with as much information as we can before you select a treatment option so that you can make the most informed decision possible. We don't like surprises either!

**We must emphasize that as eye care professionals, our relationship is with you and not your insurance company. You are ultimately responsible for all fees for both services and materials delivered to you by this office.** We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

**If you have any questions about the above information or your insurance coverage, please do not hesitate to ask. We are here to help you. Thank You!**

I have read, understand and agree to the Financial Policies Statement above and have received a copy of the Claremont Optometry Group Privacy Policy.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

Patient or parent if patient is a minor