FINANCIAL POLICY

EFFECTIVE 08/09/2021

Lifetime Vision Care, LLC is contracted with several insurance groups and is happy to bill your **primary insurance**, as a courtesy. **Any overages not covered by the primary or secondary insurance will be the responsibility of the patient.** If there are any questions regarding specific coverage it is best to contact the insurance carrier. The customer service telephone number will be found on the reverse side of the insurance card. Please note, **any deductible not met or other non-covered services are expected at the time of service.**

Medicare patients are responsible for the non-covered options of the examination.

MEDICAL VISITS – TESTING

If the treatment by the doctors is considered a medical procedure, rather than a vision care procedure, we will process the visit as a major medical claim. For questions regarding major medical benefits, please refer to your medical insurance provider.

BALANCES OVER 60 DAYS ARE CONSIDERED "PAST DUE" ACCOUNTS OVER 90 DAYS ARE ASSESSED $15.00

EXTRA FEES

NSF Checks	$35
***Collection Accounts- Delinquent Balances over 90 days may be assigned to an outside collection agency. Certified fees will be assessed whether notification is accepted or refused.**	**$50 plus any rebilling fee incurred**
No-Show or Appointment Cancellation with less than a 24 hour notice	**$50**

QUOTE OF INSURANCE BENEFITS

Quotes received from insurance companies represent a quote of benefits and ***are not a guarantee of payment.*** *I understand my primary insurance will be billed and will make direct payment to Lifetime Vision Care, LLC. I understand any portion of the bill not covered by insurance is my responsibility. Final determination of amount due can only be made once the claim is processed.*

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION

I hereby authorize payment of medical benefits directly to Lifetime Vision Care, LLC. I authorize Lifetime Vision Care, LLC to release information required to secure payments of benefits and to use this signature on all insurance submissions. I understand I am financially responsible for any charges not covered by insurance.

_____ _____

Signature of patient or responsible party Date

_____ (PRINTED NAME)