Financial Policy Effective 02/18/2022

Lifetime Vision Care, LLC is contracted with several insurance groups. As a courtesy, we will bill your **primary insurance**. **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.

EXTRA FEES

- **Balances over 60 days are considered "Past Due"**
- **Accounts over 90 days are assessed $15.00**
- NSF Checks are processed with $35 fee
- 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. These accounts will incur $50 plus any rebilling fee
- No-Show or Appointment Cancellation with less than a 24-hour notice is charged $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.*

*Insurance information needs to be provided at the time of service. If a patient fails to do so, the patient will be financially obligated to pay LVC for services/products. ***Please note: LVC billing procedures do not allow back dating/billing for the patient.***

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 payment 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**