Financial Policy

Thank you for choosing our office as your vision care provider. The following is a statement of our financial policy. If you have any questions, please do not hesitate to discuss them with our staff.

Insurance Coverage

It is your responsibility to provide our office with accurate information for billing your insurance at the time of service. It is also your responsibility to know if your visit is covered by your insurance plan fully, partially, or not at all. For example, you may be covered under your primary healthcare plan and for additional vision services under a different carrier. It is your responsibility to know if you have separate coverage. If, at the time of service, you do not provide us with your current coverage and later make us aware of additional coverage you will be responsible for any and all charges. We will gladly provide you with an itemized receipt to submit to your insurance for reimbursement. Information of this type is only 100% accurate only if you obtain it directly from your health plan. In the event you do not confirm this information and the insurer refuses full or partial payment, you will be responsible for the cost of the services provided. *Initial:*______

Routine and Medical Eye Exams

Our office participates with certain plans for routine eye exams. A routine eye exam is, by definition, a "Well Vision" exam for people with no eye disease or symptoms of disease. Your eyes will be examined for any needed correction (glasses, contacts, etc.) or any potential indicators of eye disease. If the doctor detects any medical condition, the exam may become a medical eye exam and will be submitted to your medical insurance. Please note that some insurance plans consider a routine eye exam to be a non-covered service. *Initial*:______

Glasses and Contact Lens Exams

Exams for glasses and contact lenses are separate exams. If you desire both exams on your visit, you will be charged a contact lens fitting fee for a contact lens exam. Contact lens fitting fees many not be covered under your insurance plan. We require this fee to be paid at the time of service. *Initial*:______

Amounts Due from Patient

Insurance co-payments will be collected at the time of service. If we do not participate with your insurance plan, you are to provide full payment at the time of service. If you are using insurance, we will make every effort to collect full and accurate fees specific to your plan. However, if there is a fee that your insurance charges and we did not collect it at the time the order was placed it must be paid in full before the glasses or contacts will be dispensed. *Initial*:______

Amounts Determined "Not Covered"

In the event a health plan determines a service to be "not covered," you will be responsible for the complete charge. An example of this is the refraction. A refraction is a test to obtain your best corrected vision, to determine the need for glasses, surgery, and/or medicine. Most medical insurance plans, including Medicare, do not cover refractions. Our office will collect the refraction fee and any co-payments at the time of service. *Initial*:______

Release of Medical Information and Statement of Notice and Privacy Practices

I hereby authorize Dr. Crawford and Dr. Weltmer Family Eye Care to release to my insurance or any other third party payer any and all information necessary to process a claim on my behalf. I authorize my insurance to assign my benefits directly to Dr. Crawford and Dr. Weltmer Family Eye Care. Your medical information is personal to you by law and Dr. Crawford and Dr. Weltmer Family Eye Care is required to make sure it is kept private. You may obtain a copy of our privacy policy by request. *Initial*:______

I have read and understand the financial policies of Dr. Crawford and Dr. Weltmer Family Eye Care.

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Signature of Patient (or responsible party) Date