FAMILY EYECARE OF SCOTTSDALE

FINANCIAL POLICY

Payment

Payment is due in full at time of service. We accept cash, check, Visa, MasterCard, American Express, Discover and Care Credit

- Payment for all prescription devices, lenses, contact lenses and materials must be made ***before*** orders are placed.
- Orders are processed at time of full payment and cannot be cancelled after payment is received.
- Account balances over 30 days will receive a finance charge of 1.0% per month (12% APR).
- Checks returned for insufficient funds will incur a fee of $40 in addition to the amount due.
- Accounts not paid in full within 90 days are automatically placed with an outside collections agency.

Insurance

Family Eyecare of Scottsdale is not responsible for charges NOT covered by your insurance company.

- Insurance cards must be presented along with necessary forms at time of appointment
- We cannot guarantee the accuracy of information given by insurance companies regarding coverage.
- It is the patient's responsibility to determine whether insurance company covers services rendered.
- We will bill your insurance if we are a participating provider for your program.
- We may bill your vision, medical insurance or multiple plans depending on coverage policies and your vision or medical condition(s).
- You will be billed for all charges not reimbursed by your insurance company. Refer to the Explanation of Benefits provided by your insurance company for additional fees that are your responsibility.
- Deductibles, co-payments and non-covered professional services or materials are due at the time of service or when materials are ordered.

I understand that I am responsible for the balance on my account for services rendered and/or materials purchased. If delinquent balances are referred for collection, I agree to pay all costs and attorney's fees.
I authorize that my insurance payments are paid directly to Family Eyecare of Scottsdale.
I authorize the use of this signature on all insurance claims.
I also authorize release of records to my insurance company as needed.

I have read and agree to the Financial Policy of Family Eyecare of Scottsdale.
This agreement remains in effect until revoked by me with written notification of Family Eyecare of Scottsdale.

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Signature Print Patient Name

Relationship to Patient (Please Circle) Self Parent Guardian Date _____