COMPLETE EYE CARE

1012 1st Ave N
Great Falls, MT 59401

POLICY REGARDING FINANCIAL OBLIGATIONS

If you have an insurance policy that we are a provider for, we will submit a claim for covered services and materials on your behalf. Upon signing this form, we have your consent to bill insurance on your behalf. To ensure prompt processing of your claims, you are required to provide us with ALL *medical and/or vision* insurance carrier information and any additional personal information required for filling a claim at least *48 hours* prior to the time of your initial visit. This includes your medical and/or vision insurance cards so that copies may be included in your file. **It is your responsibility to notify us of any changes to your insurance status.** By signing below, you authorize your insurance company to pay Complete Eye Care directly. Any non-covered services or materials, including co-pays, will be your responsibility and billed accordingly.

The following policies governing insurance claims and payment for services apply:

1. Statements at our office are generated and mailed within 30 days of service; all charges are to be paid within 90 days, whether that charge is acquired on the date of service or once an explanation of benefits from your insurance provider has been received by our office.
2. If you do not have insurance, or we are unable to verify benefits ahead of time, payment in full is required at the time exam services and any applicable testing are performed.
3. Payment from insurance is determined by the insurance provider. Our office does not guarantee that your insurance will pay for any or all the examinations or procedures performed during your visit. We will perform our routine insurance billing procedures after we verify your coverage. However, if for any reason, your insurance is denied and does not pay, you are responsible for the entire balance due for services rendered and will be billed accordingly.
4. If your insurance has not paid within 90 days, you will be billed the balance due and will be reimbursed when, and if, the insurance pays. Questions regarding coverage should be directed to your insurance provider as insurance coverage is specific to your provider and plan.
5. I understand that should I default on payment of my account and collection agency services are required all costs of collections up to 40% of the balance, including attorney/court costs, will be added to the balance of my account.
6. If your insurance carrier requires that you have a referral to visit our office, it is your responsibility to obtain that referral. Please make sure that all referrals are received by this office before the time of your appointment.
7. A minimum of a 50% deposit is required to place an order for eyewear and contact lenses, with the remaining balance to be paid in full at the time of pick-up.
8. **Glasses and contact lenses are a personalized purchase and cannot be returned or exchanged.**

Your signature below confirms that you have read and agree to the above terms and conditions.

Patient Name: _____ Parent/Guardian (if patient is a minor): _____

Signature: _____ Date: _____

Reviewed and updated 2019.