



Insurance and Financial Policy

We have prepared the following information to assist you in understanding the financial part of your vision and medical eye health care. If you have questions after reviewing our policy, please contact us at 541-342-3100.

Insurance Claims

As a courtesy, we will bill your insurance company. It is very important that you provide us with accurate and up to date insurance information. We ask that you bring both your most current vision and medical insurance cards with you to your appointment.

Insurance co-payments, deductibles, and non-covered charges are due and payable at the time of your office visit.

Insurance coverage is an agreement between you and your insurance carrier. This coverage varies by company and individual policy. The amount your insurance will pay toward your vision or medical eye care depends on your policy. It is your responsibility to check with your insurance company to verify coverage for vision care and medical eye care. Our office is not responsible for collecting insurance monies or negotiating a settlement on a disputed claim. It is ultimately the responsibility of the patient to pay for the vision and medical services provided to you, within the limits of our financial policy.

Secondary insurance companies will be billed, provided we receive a check from the primary insurance company and a copy of the "Explanation of Benefits." Upon receipt of this information, we will bill the secondary insurance company on your behalf.

Financial Policy

All charges are due and payable within 30 days of your billing statement. This does not include co-payments and/or down payments which are due at the time of service.

Your account will be charged a service fee of \$25 for all checks returned to our bank.

In the event your account is assigned to a collection agency, an Administrative Fee will be charged. The fee is the greater of \$50 or 20% of the unpaid balance.

No refunds will be issued for \$5 or less on your account.

For questions relating to your account, please contact our Business Office at 541-342-3100. The office is willing to assist you in keeping your account current.

Financial Responsibility

I understand that I am financially responsible for all charges for the services and materials provided to me. I understand that all non-covered charges, copayments, and/or deductibles are due at the time of service. I authorize release of any information necessary to process my insurance claim. A photocopy of this authorization may be used in place of the original. I hereby authorize payment for my vision care and medical services to be made directly to Lifetime Eye Care, Inc. I authorize release of my medical records to other health care providers upon my request.

Signature: _____
Patient/Parent/Legally Financial Responsible Party

Date