Sisson-Boyer Eyecare, LLC Financial Policy

Thank you for choosing Sisson-Boyer Eyecare as your eye care provider. We are committed to providing you with quality care. A clear understanding of our financial policy is important to our professional relationship, and payment for services is a part of that relationship. We welcome your questions about our fees, policies, and your responsibilities. Please notify our office with any changes, including name, address, telephone number, email address, and insurance coverage.

Insurance. We participate with most medical insurance plans, including Medicare. We do not participate with Medicaid or disability plans. We participate with Eyemed and VBA vision care plans. Vision plans only cover basic eye health screenings, and do not include the diagnosis, management, and treatment of ocular disease. They may cover materials such as eyeglasses or contact lenses. Medical insurance applies for visits regarding ocular health disorders and symptoms related to eye health problems. This includes existing health conditions that may affect your eyes, such as diabetes. The doctor will determine if a medical condition exists, based on his/her findings and your case history.

If you are insured by a health plan that we do not participate with, you will be considered self-pay, and payment is expected at each visit. If you are insured by a participating plan, but fail to provide an up-to-date insurance card, or we are unable to verify your coverage, you will be considered self-pay. Understanding your insurance benefits is your responsibility. Please contact your insurance plan with any questions you may have regarding your coverage.

Eyewear. When ordering eyeglasses or contact lenses, we expect payment at the time of the order. Eyeglasses are “custom-made” and fit your precise refractive status and unique facial structure; therefore, eyewear is not “returnable”. In the event that you have difficulty adapting to your eyewear purchased in our office, the doctor may need to adjust your prescription. These changes may be covered at no cost, but must be made within the first 45 days from the original order date. Eyewear purchased from another location is not eligible for a refraction recheck. Rechecks on eyewear purchased elsewhere will be charged a fee of $42.

Copayments and deductibles. All office visit copays must be paid at the time of service. This requirement is part of your contract with your insurance plan. For your convenience, we accept Visa, MasterCard, Discover, Care Credit, cash and checks. If a check is returned for non-sufficient funds, we charge a fee of $50, in addition to any associated bank fees, payable by cash only. Accounts with NSF check return will be flagged as cash or credit card only.

Non-covered services. Please be aware that some of the services you receive may be considered non-covered by Medicare or other insurers. You will be expected to pay for these services in full at the time of visit.

Proof of insurance. All patients must complete our patient information form before seeing the doctor. We will obtain a copy of your photo ID and current insurance cards as proof of insurance. If you fail to provide us with the correct insurance information, you will be responsible for the balance of a claim.

Claims submission. When billing insurance, we submit claims as quickly and efficiently as possible to assure payment by your insurance plan. Please be aware that the unpaid portion of your claim is your responsibility. Your insurance contract is between you and your insurance plan; and we are bound to follow the rules of your contract.

Coverage changes. If your insurance changes, please notify us before your next visit so we can make updates and help you receive your maximum benefits.

Nonpayment. It is our policy that accounts be sent two statements. If past-due payment is not made, expect a phone call to make payment arrangements. If no resolution can be made, the account will be sent to our collection agency and delinquent patients may be discharged from the practice.

Minors. A parent or guardian must accompany any patient under the age of 18. Another responsible adult may accompany the patient, if we have written consent from a parent or guardian. The parent or guardian assumes responsibility for any fees due based on the above policies.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____/_____

Patient Signature / Date

If you are signing as a personal representative of the patient, please indicate your relationship. If you are signing for a minor, you attest that you have the legal authority to make medical decisions for the minor and consent to such care. Please indicate any other parent, step-parent, guardian or other individual(s) authorized to make medical decisions for the minor.

_____ / _____

Representative Signature / Relationship to Patient