Round Rock Family Eye Care
Patient Financial Responsibility and Treatment Authorization Statement

The law requires that we inform you of your rights related to our payment policies and your personal health information. This statement has been prepared so that you might know what to expect from our practice and what your responsibilities are to us. If you have further questions, please discuss them with our office staff.

Our financial and insurance filing policies are as follows:

Full payment is due at the time of service. For your convenience we accept Visa, MasterCard, Discover, American Express, Care Credit, Cash and Checks. Annual exams will be granted a courtesy discount of 10% when full payment is made on the day of service (excluding copays, insurance overage and other discounts). Please be aware that all merchandise sales are final unless the terms of sale or policy of the seller makes it otherwise

We are a provider for most local third-party insurance plans. As a courtesy we will bill these carriers (according to HIPAA security standards) for you. We will collect for the copays and for non-covered services. You are fully responsible for all services not paid by your insurance company. For these non-included services, you may be asked to sign an Advanced Beneficiary Notice (ABN) indicating your knowledge of and agreement to obtain the service. Our office recommends an all laser scan; The Optomap (retinal photograph) and iWellness (digital scan of the retinal layers) in lieu of dilation. These services are not covered by insurance, the fee for this procedure is $45.

We will do our best to obtain knowledge about your insurance benefits before your arrival. Insurance companies do not always pay claims as benefits were quoted. You may end up owing us an outstanding balance or we may owe you money after a claim has been billed. We expect that you will make a prompt payment for any outstanding balances within 30 days of being billed. We will extend the same courtesy to you by refunding all balances $10 or greater to you within 30 days of payment. If the balance is less than $10 a credit will remain in your account unless refund by check is requested. After 90 days of non-payment by a patient Round Rock Family Eye Care reserves the right to disclose to a Collections Agency all relevant and personal account information necessary for collections. An additional fee of 50% of your statement balance will be assessed and sent to the collection agency to cover collection fees.

If at any point a check is returned to our office from a financial institution Round Rock Family Eye Care reserves the right to charge a returned check fee of $30. Round Rock Family Eye Care also reserves the right to disclose to William County Hot Check Division all relevant and personal account information necessary for recuperation of the bad check.

We ask that you complete the process of addressing your visual needs by filling your prescription in our optical. Our opticians are highly trained, and you will receive the best measurements and materials. When prescriptions are filled elsewhere less than optimal results are achieved. Online and chain opticals use older technologies and lower quality materials. When a doctor visit is required for glasses that were purchased elsewhere the charge is $30. By purchasing through us you will save time, hassle and achieve better vision.

By signing below, I, the undersigned, agree to accept full financial responsibility for services and/or materials obtained from Round Rock Family Eye Care for myself or my dependent. I do hereby give my consent to obtain diagnosis and treatment for me or my dependent from Round Rock Family Eye Care. My signature verifies that I have read the above disclosure statement, understand my responsibilities and agree to said terms.