Insight Eye Clinic Payment Policy

I. Patients are responsible for payment for all services provided by Insight Eye Clinic. As a courtesy, we file primary insurance on the patient's behalf. All copayments, coinsurance, deductibles and non-covered services/items are due at the time rendered. Any portion of the bill denied and not paid by insurance will be the patient's responsibility. Insurance coverage is a contract between the patient and his/her insurance carrier and it is the patient's responsibility to understand coverage. For urgent care, a $100 deposit will be collected prior to the office visit. The remaining balance will be billed either to the patient's medical insurance and/or directly to the patient. The patient will be mailed a refund if insurance covers some or all of the deposit amount.

II. Insight abides by law and insurance company rules in billing either medical insurance or the patient's vision plan depending on the reason for visit and the diagnoses found.

Medical Eye Exam:	Routine Eye Exam:
• Comprehensive eye exam • Billed to medical insurance • Dry eye, red eyes, flashes, floaters, eye pain, injuries, infections, vision loss • Covers patients with diabetes • Cataracts, glaucoma, macular degeneration treatment	• Wellness Exam (a check-up for your eyes) • Billed to Vision Plans (VSP, EyeMed, etc) • For patients with no ocular disease • If eye disease is found, the doctor may discuss whether you should switch to a medical eye exam or come back for one.

III. If the insurance company requires a referral from the patient's primary care provider before visiting us, we ask that the patient obtain them prior to making an appointment with us. This is important as retroactive referrals are usually not permitted. If a need for diagnostic testing that requires a referral is found during the eye exam, we assist in this process.

IV. Patients who self-pay will get a discounted fee schedule for paying in full at the time of service. No insurances are to be billed for self-pay services/items.

V. For cosmetic services, a non-refundable deposit is to be collected when making the appointment and will be credited toward the bill upon completion of services. Regular no-show fees are applicable (see below).

VI. Any and all materials must be paid in full before ordering and dispensing.

VII. We strive to provide timely services and therefore never double book our appointment slots (the exception being walk-in emergencies). We reserve time to provide our patients the undivided attention necessary for optimum care. If the patient cannot make his/her appointed time, we request at least 24 hours notice. If not, the patient will be billed a $35 no-show fee.

VIII. Checks returned for insufficient funds, closed accounts, or other problems may be subject to a $35 service charge.

IX. Account balances over 60 days are considered delinquent and are charged a monthly interest rate of 2.25% from the date of service. If not paid in full by 90 days, the bill will be sent to an outside collection agency which may have a negative impact on the patient's credit score. Patient is responsible for all costs associated with any action necessary, including court costs and reasonable attorney's fees, to collect payment on past due accounts. Past due balances are due in full before receiving additional services.

X. A contact lens exam includes up to three visits within 60 days. More than three visits indicates a complicated/specialty fit. As such, each additional visit is subject to standard office visit fees. Follow ups outside of the 60 day time frame is subject to a refit fee.

I hereby authorize payment of medical and vision benefits from my insurance(s) to Insight. I have listed all medical insurance and vision plans from which I may receive benefits. I understand insurance information must be presented prior to services rendered and cannot be retroactively billed. I also understand that if I present my secondary insurance but not my primary insurance to Insight, the secondary insurance will deny payment making me responsible for payment in full. I understand that insurance is not a guarantee of payment. I hereby accept responsibility for fees that exceed the payment made by, are not covered by, or are retracted by my insurance(s). I understand and agree to all of the above. I accept these responsibilities for my care or for the minor named below.

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Print Patient Name | Signature of patient or guardian | Date