Family Eyecare LLC Policy

We must emphasize that as a medical care provider, our relationship is with you, not your insurance company. While filling insurance claims is a courtesy that we extend to our patients, all charges are your responsibility.

1. **It is your responsibility to know your insurance benefits prior to the visit. The contract is between you, the insurance company and/or your employer.**
2. **Cancellation/No show:** If an appointment is missed or cancelled with less than a 24 hour notice, there will be a charge of **$50.** This fee is not covered by any insurance.
3. **Referral form:** If your insurance policy requires a referral, it is your obligation to get a referral prior to your visit. All charges will be your responsibility.
4. **Fees/Insurance:** Our fees fall within the usual, customary and reasonable rates by most companies. If your insurance denies payment it is your duty to resolve the issues with your carrier.
5. **Contact Lens fit** is **$60** unless otherwise stated by your insurance (every year). Additional **$25** applies to first time contact lens wearers.
6. **Copay: We collect copayment the day the services are rendered. Each and every visit will require copay if stated with your insurance. We will charge $25 additional, if payment is not made the same day**. **We do not accept Checks.**
7. **Deductible:** A deductible is the amount that needs to be paid out of pocket before your insurance makes a payment. Family Eyecare will collect deductible out of pocket prior to visit, if the insurance makes a payment, a **refund check** will be issued.
8. **Balance:** If you have an outstanding balance, it will be collected prior to being seen by the doctor. Failure to pay the balance could lead to collections.
9. **NO REFUNDS OR EXCHANGES.**
10. **Glasses and contacts** orders require 50% deposit to start and will only be held for 30 days. Once an order is placed it cannot be cancelled or modified. Glasses will be dismantled after 30 days and any payments made towards the materials **WILL NOT BE REFUNDED.**

ANY VIOLATION OF THE ABOVE STATED POLICY CAN LEAD TO TERMINATION AS A PATIENT.

I have read the above Family Eyecare Financial Policy, I understand and agree to abide by its terms.

Patient Name: ____________________Signature: _____________________Date:_________________

Dilation Consent

A comprehensive eye examination includes pupillary dilation in order to better view the back of the eye (the retina). Dilation requires instilling drops into the eyes, which will dilate the pupils, causing sensitivity to light and near vision blur, that will last for several hours. You may do this today, reschedule for a time that is more convenient for you, or decline the procedure done. There is no extra charge for this procedure with vision insurance, if using medical insurance there will be another copay if rescheduled. I have been informed of the risks/ benefits of dilation and choose to (circle one)

Do   Do Not

Signature ____ **Date:** ____________