Colonial Heights Vision Center Optometry, P.C.

Our Financial Policy

Thank you for choosing Colonial Heights Vision Center Optometry, P.C. as your vision care provider. The following is our financial policy which requires you read and sign prior to any treatment.

Regarding Insurance

We may accept assignment of insurance benefits. However, we do require that all co-payments be made at the time of service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information and an original insurance card at each visit to copy and keep on file. Your insurance company is a contract between you and your insurance company. We are not part of that contract. Please be aware that some and perhaps all of the services provided maybe non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance policies. You will be responsible for these balances.
Initials:_____

Adult and Minor Patients

Adult patients are responsible for full payment at the time of service. The adult accompanying a minor and/or the parents (or guardian) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized with Visa/Mastercard or payment by cash or check at the time of service has been verified.
Initials:_____

Return Check

There will be a $35.00 return check fee on all returned check. In the event that a check is returned for insufficient funds, you will have only 14 days to pay by presenting cash, money order or credit card to cover the amount of the check plus the $35.00 fee. Any returned checks not picked up will be turned over to an attorney for collection. **Initial:**_____

Collection Fees

In the event your account is turned over to the collection attorney/agency, you will be responsible for all collection cost including interest and attorney fees. **Initial:**_____

Fees for Letters and Forms

Our Optometrist or Optician will be more than happy to fill out any necessary forms that you may need. Please be advised that due to the time required to dictate and complete letters and forms there will be a fee for this service. These cost are considered non-covered by insurance companies. **Initial:**_____

Patient records

If you would like a copy of your records there is a $12.00 fee and you must fill out a release form. **Initial:**_____

Telephone and Fax Policies

Our policy is to avoid faxing medical records, however, in the event of an emergency situation; consent is made to share information with other providers for continuity of care. I give Colonial Heights Vision Center Optometry, P.C. permission to electronically transmit (fax) medical information. **Initial:**_____

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Signature of Patient or Responsible Party Date