NORTHLAND EYE SPECIALISTS
816-792-1900

1200 Landmark Ave
Liberty, MO 64068

8660 N Green Hills Rd
KC, MO 64154

FINANCIAL POLICY

1. Your insurance policy is a contract between you and your insurance company. We file as a courtesy.You are responsible for providing the correct insurance and policy holder information in order for us to file your insurance claim. You are responsible for making sure that your doctor is contracted with your insurance. ***We file the insurance provided at the time of service, if that is not correct, we will not refile.*** Failure to do either will result in you being responsible for charges incurred. All charges are your responsibility whether your insurance company pays or not. Not all services are covered by insurance

_____I am planning to use my **vision** insurance today.
Initials

_____ I am planning to use my **medical** insurance today.
Initials

_____ I will not be using insurance today and I accept full financial responsibility.
Initials

2. All co-pays, deductibles, and fees must be paid at the time of service. As a courtesy, we accept cash, checks and most major credit cards.

Initials:_____

3. Contact lenses and/or optical goods fees must be paid in full at time of delivery, with 50% being paid prior to the order being placed.

Initials:_____

4. **Refraction test**. One of the most important parts of your eye exam today is the refraction. This test is used to determine whether you can be helped in any way by a new glasses prescription. It is also how we determine the best possible visual acuity and function of your eye, which is essential medical information for us to have as we assess your eyes and look for problems. **Even if you are not interested in purchasing new glasses today, the test is still vital information that the doctor needs in order to thoroughly assess your eyes.** It is **NOT** a covered service by Medicare and many other MEDICAL insurance plans. These plans consider refraction a "vision" service not a "medical" service. Our office fee for refraction is $40 and is only charged once per year. **This fee is collected at the time of service** in addition to any co-payment your plan may require. I understand that the refraction charge is a non-covered service and I accept full financial responsibility for the cost of this service.

Initials: _____

5. **Contact Lens Fitting:** Fitting of contact lenses is a separate identifiable service from your eye exam. There is a minimum fee of $60.00 for spherical contact lenses and $80 for toric/multifocal contact lenses.

A contact lens prescription cannot be determined without a fitting. Contact lens prescriptions are only valid for ONE YEAR. If you wish to renew your contact lens prescription, you will be required to participate in a contact lens fitting/evaluation. During this fitting, the doctor will determine which contact is the best for your unique eyes. Since your eyes may change from year to year, it is important to re-evaluate your contact lenses, even if you have worn the same type of lenses for several years and are, once again, refitted for the same contact, so as to avoid discomfort and/or possible damage to your eye. If you have never worn contact lenses in the past, the contact lens fitting may range from $100-$250 depending on the type of contact lenses needed for your eyes (the fee will include a separate instruction appointment and at least one follow-up visit). **I understand that if I am interested in contact lenses, currently wearing contact lenses, or receive trial contact lenses today, I will accept full financial responsibility for the contact lens fitting and the fee is due at the time of service whether I decide to order contact lenses today or not.**

Initials:_____

6. Accounts are considered past due 30 days after your insurance pays. We reserve the right to submit accounts that are not paid within 90 days to a collection agency. All past due accounts are subject to 1.5% interest per month. You agree, in order for us to service your account or to collect any amounts you may owe, our organization's representative, ancillary providers, HIPAA business associates, vendors, and the representatives of our debt collection agency, may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. Our organization's representative, ancillary providers, HIPAA business associates, vendors and the representatives of our debt collection agency may also contact you sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I/We have read this disclosure and agree that the Lender/Creditor, it's ancillary providers, HIPAA business associates, vendors, and it's debt collection agents may contact me/us as described above.

Initials:_____

7. I have been offered a copy of HIPAA Privacy practices. I hereby acknowledge that I have read, understand and agree to the terms of this document relating to insurance coverage, payment of my services and HIPAA practices.

Initials:_____

Patient Name:_____Date:_____

Patient
or Guardian Signature:_____