Focal Point Vision Financial Policy

Thank you for choosing Focal Point Vision as your healthcare provider. We are committed to providing you the best available medical care. Our personnel will be pleased to discuss our fees and this policy with you at any time.

We ask that all patients read and sign our financial policy as well as complete our Patient Information form prior to seeing the physician. Payments for services are due at the time services are rendered. We accept cash, check, VISA, MasterCard and Discover.

In special instances, we may accept assignment of insurance benefits. However, you must understand that:

1) Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you. We cannot become involved in disputes between you and your insurer regarding deductible, co-payments, covered charges, secondary insurance and "usual and customary charges".
2) All charges are your responsibility whether the insurance company pays or does not pay. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
3) Fees for these services, along with unpaid deductibles and co-payments are due at the time of treatment/service.
4) If your insurance company does not pay your claim within 30 days, it is your responsibility to contact your insurer to expedite payment. After all, if your insurance does not pay, you are responsible for payment.
5) If your insurance company does not pay in full within 45 days, we require that you pay the balance by cash, check, VISA, MasterCard or Discover.
6) Returned checks and balances older than 45 days may be subject to collection placement and all associated fees.

Please note: All appointment cancellations and reschedules must be made at least 24 hours in advance.

Again, thank you for choosing Focal Point Vision as your healthcare provider. We appreciate your trust in us and we appreciate the opportunity to serve you.

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PATIENT SIGNATURE DATE

INFORMED CONSENT (Please *check* which applies)

___ I (DO) ___ (DO NOT) authorize Focal Point Vision to leave a message with any available person at my home phone number, answering machine or with the emergency contact person I have listed.

___ I (DO) ___ (DO NOT) authorize Focal Point Vision to leave a message at my place of employment.

I understand that if I schedule surgery, other people may hear my name, medical history, insurance benefits and financial liability. In the scheduling process the staff will: 1) Identify me by Name, 2) Discuss the details of my procedure, 3) Discussion of insurance benefits and financial liabilities will occur.

I have been provided with a copy of the Focal Point Vision Privacy Practices.

_____ _____

PATIENT SIGNATURE DATE