WESTHEIMER VISION

A relationship of trust · A lifetime of care

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FINANCIAL POLICY

The following is a statement of our Financial Policy, which we require that you read and sign prior to any treatment.

Payment is expected at the time services are rendered. This includes services provided for a minor patient. We prefer payment in full when ordering glasses or contacts. However, a deposit of 50% can be made to initiate the order. The remaining balance will be due at dispensing. The exception to this policy is when ordering through third party plans. All copayments and overages must be paid before glasses or contact lenses can be ordered.

We accept cash, checks, and credit cards. There is a $35 collection fee for returned checks.

Patient balances are expected to be paid within 30 days after billed. Balances not paid within 120 days will be forwarded for collection.

If you have Medicare or are enrolled in a plan we participate in, we will file a claim on your behalf. However, payment of applicable deductibles and co-pay amounts are due at the time services are rendered. If you have a plan in which we do not participate, vision or medical, we can give you a statement for submission to your insurance company. We would be glad to complete any forms required by your insurance company. For specific policy questions, please refer to your policy manual or call the phone number listed on your insurance card.

Not all services are a covered benefit and routine eye care and other procedures may be specifically excluded, depending on the insurance carrier, making the patient responsible for all charges. We will furnish you with as much information as possible before you select a treatment option so that you can make an informed decision.

SIGNATURE ON FILE / ASSIGNMENT OF BENEFITS

I authorize this form as a record of signature to be used on all my insurance submissions.

I request that payment of authorized Medicare benefits and that of other insurance companies be made on my behalf to Westheimer Vision Associates for services they furnished me.

I authorize the use of this form on all my insurance submissions for all my insurance companies.

Westheimer Vision Associates accepts the Medicare charge determination as the full charge. I am responsible only for the deductible, co-insurance and non-covered services. My deductible and co-insurance are based upon the charge determination of Medicare and other insurance companies indicated by me.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim.

FINANCIAL POLICY

I have read, understand and agree to Financial Policy.

Patient Name:	
Signature:	**Date:**