SACRAMENTO
OPTOMETRIC GROUP
"TRUSTED VISION AND EYE HEALTH CARE"

Financial Disclaimers

Eligibility for medical insurance and/or routine vision benefits

Our office will verify your eligibility for services and/or materials before your appointment. (though it is NOT always a guarantee of payment or benefits which may result in a statement after your insurance has been billed.)

If you have multiple medical or vision benefits, we will attempt to coordinate benefits between all plans in order to minimize what you owe. Sometimes insurance plans pay less than the anticipated amounts and all fees for services and/or materials are ultimately your responsibility for payment.

Please check with your administrator if you have any questions regarding your insurance eligibility, as it is a contract between you and your insurance carrier.

Routine vs medical insurance

We are required to report all diagnoses uncovered during your eye examination. If any of the diagnoses are medical in nature the visit may be billed to your medical insurance plan as a primary benefit instead of your routine vision plan.

Financial Responsibility

I understand that I am financially responsible for all charges that are not covered by my insurance. If your insurance company paid you directly for services rendered, you will receive a statement from our office**. If authorization is required for my visit but is not able to be obtained, I understand I am still financially responsible if I elect to receive services.**

We also do not get involved in legal disputes over financial or parental responsibility. The parent or guardian that accompanies the child to the visit is "that" responsible party.

I further understand that I will be responsible for payment when I place an order for eyewear materials**.** With electronic records all materials ordered are submitted once entered. If an order is not cancelled the same day as you placed there may still be charges you will be responsible for.

I have read and understand the information above, and by my signature, agree to abide by this policy.

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Signature of: Patient or (Parent or Legal Guardian) *Date*

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Printed Name of Patient