Raymond J Ruckman OD
& Associates

111 West Tenth Street, Carson City, NV 89703
Phone: 775-883-4664 - Fax: 775-883-4750

PATIENT FINANCIAL RESPONSIBILITY

Eye Care Services: Our office provides a full scope of eye care services including routine **vision care** (ie: check-ups, glasses and contact lenses), as well as **medical eye care** services such as treatment for eye infections, dry eye and lid disease, treatment and evaluation of ocular allergy, cataracts, Macular Degeneration, Glaucoma and trauma related care. Payments for all services rendered by this office are the responsibility of the patient. Regardless of the amount or type of insurance you or your employer has purchased, each patient assumes full responsibility for all fees incurred. You are responsible for all charges not paid by your insurance carrier. Depending on the nature of your visit, we may be able to bill your vision plan insurance, your medical insurance or both. Please present all of your insurance information to the receptionist upon arrival.

Vision Care Plans: We are contracted with most Vision Care plans. We accept VSP, Blue View Vision, Spectera, Davis Vision, Superior Vision, MES, and Most EyeMed plans.

Medical Eye Care: **PPO's** - Your medical insurance may be able to be billed for certain eye conditions and procedures that your insurance company deems medically necessary and has included in your policy. You will be given a "Health History and Symptoms Form" to fill out in advance. Even with this information, it is impossible for our office to determine with any certainty what, if any, charges will be covered by your insurance company. What your insurance company deems medically necessary has no bearing on the quality of care we provide. Our services are aimed at providing you with the best care possible, regardless of insurance.

Materials: A 50% deposit is required at the time an order is placed for contact lenses or glasses. The balance is due upon dispensing pickup or delivery. If after 60 days the order has not been picked up and the balance has not been paid, you will receive a message that the order will be canceled and the deposit will be forfeited if not paid and picked up within the next 15 days.

Methods of Payment: All major credit cards, bank debit cards, health savings cards, checks and cash will be accepted. Return checks will be charged $30.00 fee. Balances due, notwithstanding insurance balances, that are not paid in full within 60 days will be sent to an outside collections agency.

You (or your legal guardian) are responsible for the payment of your account including payment of copays, coinsurance, all other procedures or treatment not covered by his/her insurance plan and all direct or indirect fees incurred in collecting any outstanding balance. While we assist in filing for insurance, we cannot guarantee coverage. As the insured, you are responsible for knowing your insurance benefits and requirements for coverage and ensuring that any necessary referrals or authorizations are obtained before receiving services. In the event of a dispute or rejection of a claim you are responsible for payment. ____________ Please Initial

I have read, understand, and agree to the policy outline above.

____ ____________________________
Printed Name Date

Revised 5-1-18