FINANCIAL POLICY

Payment of all services and materials are payable at the time of your visit unless other arrangements are made in advance.

We cannot accept your insurance as payment unless you have a specific vision plan, for which we are providers. In that case, you will be responsible for your co-payments, and any additional charges for services that are not covered by your insurance company.

If we are a provider on your insurance panel, we will give you an estimate of your co-payment. We will know the exact amount only after we bill your insurance company, and they have issued an explanation of benefits with payment.

Your insurance is a contract between you, your employer, and the insurance company. We are not a party of that contract.

Not all services and materials are covered in all insurance contracts. Some insurance companies arbitrarily select certain services they will not cover. We cannot render services or provide materials on the assumption that our charges will be paid by your insurance company. You are responsible for non-covered services and materials.

There are additional fees for contact lens evaluations and follow up visits.

I understand and agree to these policies.

_____ _____

Patient's Signature Date

_____

Patient's Name (Please Print)

INSURANCE EXPLANATION

If the Domiano Eye Care Center is not on your vision or health insurance, this is considered an out-of-network visit.

1. Please note that professional services are rendered and charged to the patient and not to the Insurance Company. You are responsible for service and materials fees.

2. Your insurance company may reimburse you depending on your eligibility and plan, but we are not responsible for collecting from your insurance company.

3. Payment is expected when services are rendered for all patients.

   Even if an insurance claim is filed, you will receive a statement each month if your account has a balance due. This office cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim. You are responsible for payment of your account within the limits of our credit policy.

4. If you have any questions we will assist you. Your insurance carrier will determine your eventual reimbursement.

I understand and agree to these policies.

_____ _____

Patient's Signature Date

_____

Patient's Name (Please Print)