Financial Policy

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 (ie: treatment and evaluations for allergies, dry eye, traumas, diseases, cataracts, glaucoma, and macular evaluation.) 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 your insurance information to the receptionist upon arrival.

Professional Service Policies: Our follow up visits are intended to assess ocular health after treatment has been initiated. While the follow up appointment is in conjunction with an initial visit it is still considered a thorough evaluation of the current condition and will be billed as its own appointment. Contact lens follow up visits are to assess the quality of each patient's vision with the new contact lenses. We also determine if the patient is experiencing any adverse physiological changes secondary to wearing new contact lenses. Each patient is required to return with the contact lenses on, within one to two weeks of dispensing the contacts. Within 3 months all contact lens follow ups are covered under the initial contact lens fitting fee. If a follow up appointment is not completed within 90 days of the original exam date, the patient will be required have a new contact lens fitting fee of $70. Additional fees or a new exam may be required if it has been too long to base the fit on the previous exam. This will be at the doctor's discretion.

Payment: Full payment is due at time of service. We accept Cash, Check, Visa, MC, Discover, AmEx, or Care Credit.

Signature Authorization: I request payment of authorized medical insurance benefits be made either by myself, or on my behalf for any services furnished to me by the staff and doctors affiliated with Pikes Peak Eye Care. **I understand that I am responsible for any procedures not covered by my insurance company for any reason. I understand that I am responsible for any co-payments, deductibles and /or contact lens fittings.**

I authorize the release of any medical information to the authorized third party necessary to process claims for services rendered.

I understand and agree to the above terms of payment. I understand that if I fail to make my payments, my account may be turned over to a collection agency. I understand and agree to pay reasonable attorney and/or collection fees accrued should my account become delinquent.

Patient Name (Printed) _____ Date_____

Patient Signature (or Parent/Guardian if patient under 18yrs)_____

HIPAA Privacy Acknowledgment of Notice of Privacy Practices: I acknowledge that all information in my medical records is confidential and will be handled only by the associates of Pikes Peak Eye Care.

Patient Signature (or Parent/Guardian) _____ Date _____