DEAN OPTICAL

Financial Policy Statement and Patient Agreement

Dean Optical is committed to providing our patients with the best possible Optometric care and minimizing healthcare costs. Our prices are reflective of the usual and customary charges for our area. The following policy statement and financial agreement outlines the patient's and the practice's financial responsibilities concerning payment for services:

1. Our Optometrists are preferred providers for numerous insurance plans. Our billing office will submit a claim for services rendered for patients that are members of one of these plans. However, the patient must first complete all necessary insurance information, including any special forms, before leaving the office in order for our billing office to submit a claim on behalf of a patient.

2. For those insurance plans that do not list our doctor's names as preferred providers, our billing office will gladly file claim on a patient's behalf for reimbursement. Payment in full, however, is expected at time of service.

3. It is the patient's responsibility to pay all co-payments at time of service as specified by their insurance plan. If a patient operates under a self-pay system, payment in full is expected at time of service.

4. It is the patient's responsibility to pay all deductible, co-insurance and/or non-covered services within sixty (60) days after insurance has processed your claim and identified your portion.

5. **Dean Optical accepts cash, debit card, MasterCard, Visa, Discover, American Express or Care Credit payment for payment of all services.**

6. Due to strict timely filing requirements, it is the patient's responsibility to provide our office with active insurance information at the time service is provided. The practice must verify insurance for each office visit. Please be aware that if active insurance information is not provided, the patient will be liable for all services denied coverage because timely filing requirements have not been met.

7. Patients are responsible for obtaining and presenting insurance referrals or authorization as required by their insurance plan.

8. Payment of claims can be delayed. Insurance companies may require additional information from the patient and/or your Optometrist. Patients are responsible for completing all insurance requests promptly and notifying the practice when the requested information has been sent in the event a claim needs to be re-filed or further information is needed.

9. The patient is responsible for making payment even if they are disputing the claim with their insurance company. Dean Optical will refund a patient's payment if insurance re-processes a claim and makes any additional payment.

10. Dean Optical has a 24 hour notification policy if the need to cancel an appointment arises. This policy allows us to fill a needed time slot and allows your doctor to accommodate a patient who may need acute medical eye care. Failure to cancel an appointment 24 hours prior to the scheduled appointment time may result in a $25.00 cancellation fee depending upon type of service.

11. Medical advice or treatment given over the telephone or by email may incur a charge at the discretion of your Optometrist.

12. Our staff is happy to help with insurance questions relating to how a claim was filed, or regarding any additional information the carrier might need to process the claim. Specific coverage issues, however, can only be addressed by the patient's insurance member services department.
(Please see the number provided on your insurance card.)

13. Please note that in conformance with HIPAA regulations, Dean Optical will not disclose any protected health information, including financial information, without your authorization, except as described in our Notice of Privacy Practices.

14. **I understand that in the event an unpaid balance (over 90 days past due) is placed for collections with any third party collection agency, a collection fee will be added to the total amount due and owed by me. The fee represents the cost incurred by Dean Optical to collect amounts owed under this agreement by the signer's failure to pay as specified in this agreement. Please know that if your patient balance remains unpaid you may be discharged as a patient of our practice.**

Please sign below to indicate that you have read, understood and will comply with Dean Optical's financial policies and your obligations as indicated above.

_____ _____
Patient Name (please print) date

_____
Signature of Patient/Responsible Party

□ I have read and understand the above