Payment Policy

Patients who have insurance coverage that Valley Eye Associates **participates** with:

Valley Eye Associates participates with most insurance companies, but each plan varies by employer and insured. **Please know your plan**. Co-payments are due and payable at the time of your office visit. Deductibles, co-pays, co-insurances, and/or other balances that are your responsibility will be billed to you once these amounts are determined. If you are a member of an HMO, you are required by your plan to obtain a referral prior to your medical examination here.

If your plan requires a referral and you have not obtained one, your examination may need to be rescheduled.

You must present your insurance card at the time of your visit. If you do not have your insurance card your examination may need to be rescheduled.

Patients who have insurance coverage that Valley Eye Associates does **not participate** with:

You will be required to pay out of pocket at the time services are rendered. Please contact the physician and/or the office manager to discuss a payment plan, if necessary.

Patients who are **not covered** by insurance:

We require payment at the time services are rendered. Please contact the physician and/or the office manager to discuss a payment plan, if necessary before seeing the doctor.

Patients, who fail to provide **accurate insurance** information at the time services are rendered, will have seven (7) days to provide Valley Eye Associates the accurate insurance information. Failing to do so will result in full financial responsibility.

In an effort to provide you with flexible payment arrangements, we have expanded our payment policy.

Payment Arrangements are requested at the time of your visit.

We offer the following payment options:

____ Payment by cash

____ Payment by check

____ Payment by credit card

____ Automatic monthly billing to your Visa or Master Card

____ Guarantee any amount not covered by insurance with Visa or Master Card

Please make your choice and sign below. If none of the above apply, please see the office manager. Thank you.

Our office is fully approved and accredited user of the Visa and Master Card Health Care Program which will enable you to use your Credit Card to automatically cover amounts not paid by your insurance. You may also choose a comfortable amount to be automatically billed to your Credit Card on a monthly basis.

I authorize the release of information to determine liability for payment and/or to obtain reimbursement. I understand that if my account is not paid directly, I am responsible for the full amount and may be charged all costs including attorney/collection agency fees incurred with collection of the amount due.
I authorize the release of any medical information necessary to process claims and the release of payment to Valley Eye Associates or the physician rendering services.

Patient's Signature (Or Responsible Party): _____

Date: _____