PACIFIC EYE CARE CENTER
1270 Arroyo Way, Walnut Creek, CA 94596
Phone:(925) 945-8188 **Fax:**(925) 945-0360
Website: www.pacificeyecarecenter.org

FINANCIAL POLICY

We are committed to providing you with the best possible care and we are pleased to discuss our fees with you at any time. Your clear understanding of our financial policy and your responsibility is important to our professional relationship.

CONTRACTED INSURANCES (PPO, POS, EPO, HMO, ETC)

1. **All co-pays and fees for non-covered services and materials (like refractions, contact lens fittings, contact lenses & glasses) are due at the time of service. Deductibles, co-insurances and other balances due will be billed in a monthly statement.**
2. Some insurances require referrals and/or prior authorization for your visits. It is your responsibility to request this information from your primary care doctor. Payment on insurance claims can be affected, suspended or denied if this information is missing.
3. **A note to Medicare patients:** We are participating Medicare providers. We will bill Medicare and supplemental or secondary insurances you have that we participate with and we will receive all payments.

NON-COVERED FEES & SERVICES INCLUDE, BUT ARE NOT LIMITED TO:

1. **Refraction –** if your insurance does not cover this procedure, you will be charged $75.
2. **Contact Lens Fitting –** this is an additional exam required by law to complete a prescription for Contact Lenses, even if there is no change. There is an additional fee of $75-$125 that may or may not be covered by your insurance.
3. **Contact Lenses & Glasses –** the opticians in our optical department will go over the cost of glasses and contact lenses with you before you purchase. Insurances may or may not cover all or part of these purchases.
4. **Medical Forms –** We reserve the right to charge a $15 fee for forms that need to be completed by the doctor (ex: DMV, School Vision etc).
5. **Records Requests –** We are happy to release a copy of your records to you or anyone you authorize when requested in writing. We reserve the right to charge a $25 fee to copy your entire chart. A copy of one visit will be released at no charge as a courtesy.

CANCELLATION POLICY: We have a 24 hour cancellation policy. We ask that you contact our office if you cannot keep an appointment and leave a message if you do not speak to someone. If you do not notify us and do not keep your appointment, **you will be charged a $25 fee.**

RE-BILLING FEE: After your insurance has been billed we will send you a statement for any balance you owe. **If payment is not received in full or payment arrangements made with our billing manager, we will charge a $10.00 re-billing fee for each additional statement we have to send.**

MINORS: A parent or legal guardian must be present during the treatment of a minor child. Patient's under the age of 18 will not be seen without their parent or legal guardian present.

I have read and understand the Pacific Eye Care Center's Financial Policy. I agree that I am ultimately responsible for all charges I incur or all charges incurred by my minor child. I agree to pay all billed charges in a timely manner. I agree to provide the correct and current information for my insurance policy and billing, as well as my current personal billing and contact information.

_____ _____

Signature of responsible party (must be over 18) **Date**

_____ _____

Print Patient Name **Name/relationship if responsible party is not patient**

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NON- COVERED MEDICAL EXPENSES

REFRACTIONS

Some medical services are not covered by Medicare or other health insurances. One of our services that may not be covered are refractions. A refraction is the portion of the complete eye exam performed using lenses of different powers and the eye chart to determine your glasses and/or contact lens prescription. **If you want a new prescription during your visit, a refraction will be needed. If your vision is not 20/20 during your screening, you will need to have the refraction performed during your visit to see if your vision is correctable with lenses or if you may have an underlying medical condition.** The doctor can discuss with you whether or not you need this service. If you do need it, many insurances, including **most PPO type plans AND Medicare**, **DO NOT** cover this service. ***If it's not covered, you will be charged a $75.00 fee for the refraction, due on the day of service.***

Any insurances (including vision plans through Vision Service Plan - VSP or Medical Eye Services – MES) that do cover the refraction only cover it once per year. Our policy allows you to have re-dos of your refraction for 90 days after the initial testing date at no additional charge. If you have an additional refraction during the year after the initial 90 days, you will be charged for the service as your insurance will not cover it.

By signing below, you are agreeing that you are aware of the possible charge of $75.00 if you have a refraction and that you are aware of the policy on re-dos and additional refractions during the year.

_____ _____

Signature of responsible party (must be over 18) **Date**

_____ _____

Print Patient Name **Name/relationship if responsible party is not patient**

ONLY FOR PATIENTS WHO CURRENTLY WEAR OR ARE INTERESTED IN CONTACT LENSES:

CONTACT LENS FITTING

If you wear contact lenses, we are required to do an additional exam called a contact lens fitting. This exam checks your eye for how the lenses fit and is **required even if there is no change in your prescription or lenses** to ensure proper fit and maintain the health of your eyes. **We are required to do it each time we renew your contact lens prescription, which is good for up to one year**. Because it is an additional portion of the exam, we charge an additional fee for this service. The fee can range from **$75.00-$125.00** and will be due on the date of service. **If you have a vision plan through VSP or MES, some or all of this exam can be covered, depending on how you'd like to use your benefits.** You can discuss the best way to apply your benefits with an optician or the receptionist who checks you out. **If you do not have vision insurance, you will need to pay this fee.** This fee covers the additional visits you will have to make sure the contacts you are prescribed fit properly. You can come in for this fitting separately, but it must be with in 6 months or less from your complete annual eye exam. **By signing below, you agree that you understand that there is an additional fee for this service.**

_____ _____

Signature of responsible party (must be over 18) **Date**

_____ _____

Print Patient Name **Name/relationship if responsible party is not patient**