Peninsula Eye Care, LLC

Drs. Buck & Waldron--Optometrists

FINANCIAL POLICY

~ PLEASE READ, SIGN & DATE ~

Exam fees are based on the level of service provided. ***Contact lens services are SEPARATE FEES and are due on the day of service.***

Valid ID and insurance cards must be presented each time services are provided for which you wish us to bill insurance. As a courtesy, we will make every reasonable effort to determine what your vision and medical benefits are based on the information that you provide when you schedule your appointment. However, it is ultimately your responsibility to know and understand what your benefits are and to fully disclose all information needed to process your claim *before* services are provided. If we are unable to verify insurance coverage prior to service, you will be responsible for payment in full at the time of service. The patient (or guarantor if patient is a minor) is responsible for all fees not covered by insurance.

Payment is due when services are rendered and before materials are ordered. We accept cash, Visa, Mastercard, Discover and American Express.

Personal Checks –We prefer that you use your debit card but we will accept a personal check with the understanding that doing so may result in the delay of delivery of any materials ordered such as contact lenses or eyeglasses. Our office participates in The Check Enforcement Program, which means that should there be an instance where a check has been returned because of non payment by the bank and you fail to pay the full amount of the check plus any bank fess within one week of notification, your account will be turned over to the local Commonwealth Attorney’s office.
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I understand that my vision benefits may only cover a portion of my exam and/or materials.

I agree to pay all fees not covered by my vision benefit plan and that these fees are due on the day I receive service.

I authorize my insurer(s), including Medicare and any secondary insurer to pay Dr. Waldron.

I agree to release any personal information needed to process my insurance claims.

I agree to be responsible for any attorney fee, collection fee or court cost incurred to my account and understand that these fees may increase my bill by as much as 50%.

I agree to release any information to the above agencies in collection of my account.

Name (Please Print) ____

(parent or guardian if patient is under 18)

Signature ____ Date ____________________