FINANCIAL POLICY

This is an acknowledgement agreement between the **Konowal Vision Center** and the patient named on this form. **Payment is Expected At The Time Services Are Rendered**

We will collect your co-payment, co-insurance and any previous balance due at the time of service. We accept cash, check, Visa and Mastercard.

Returned Checks: Returned check fee is $20.00.

I UNDERSTAND AND AGREE THAT REGARDLESS OF MY INSURANCE STATUS, I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE OF MY ACCOUNT FOR ANY MATERIALS OR PROFESSIONAL SERVICES RENDERED.

MEDICARE: We do participate in Medicare Part B. We will bill services for you. You are responsible to your annual Medicare deductible and the 20% patient responsibility. You are also responsible for any services denied as not medically necessary or non-covered such as refractions.

REFRACTIONS: Refraction is a test to determine how much of one's blurred vision is due to refractive error (nearsightedness, farsightedness, or astigmatism) as opposed to an eye disease. It can also determine a glasses prescription. Refraction is NOT covered by Medicare and most commercial insurance companies. If performed during your examination, you will be required to pay the fee at the time services are provided.

AUTHORIZATIONS/REFERRALS: If prior authorization/referral is required by your insurance company and we do not receive it prior to your appointment, you will accept responsibility for payment in full for that date of service.

WORKERS COMPENSATION CASES: We require written approval/authorization by your employer and/or workers compensation carrier prior to your initial visit. If your claim is denied, you accept responsibility for payment in full.

PERSONAL INJURY/MOTOR VEHICLE ACCIDENTS: We do not file to automobile insurance. You will be responsible to payment in full.

You understand that if your account is submitted to an attorney or collections agency, or if your

past due account is reported to a credit reporting agency, you will be held liable for any attorney or collection fees. The fact that you received treatment/services at our office may become a matter of public record.

I have read and understand the above policy.

Patient/Guarantor
Signature____Date____________________