Payment Policy

The vision care we provide assesses the health of your eyes: we will collect both your medical and vision insurance, and your eye doctor will determine the insurance that we bill based on the care you receive during your visit.

You are responsible for providing accurate and up-to-date information on your primary medical and vision insurances and any secondary insurance that may apply before or during your visit. We will bill your insurance for all applicable services and will forward to you any amounts your insurance determines are your responsibility (deductibles, co-insurances, non-covered services, etc.) once the claim has been processed by your insurance. Smart Eye Care may communicate with you via mail, email, text, or phone. **If you do not provide active insurance coverage information at the time of the visit, you will be responsible for the visit charges at check-out and may seek reimbursement from your insurance.**

Smart Eye Care will notify you via monthly mailed statements of outstanding balances. If your balance is outstanding after three months, your account will be forwarded to a collections agency.

Any copayments on services or materials will be charged at check-out. Your insurance may assess a different copay amount when the claim is processed. We will issue refunds for any overcharges of more than $5.00 and account credits for overcharges under $5.00.

I**f your insurance requires a PCP referral for services, you are responsible for obtaining that referral.** If we are unable to bill your insurance due to a missing referral, you will be responsible for the charges from your visit.

Services that we are aware are non-covered, such as Optos Screenings and Contact Lens Evaluations, will be charged at check-out. Smart Eye Care staff will notify you of any out-of-pocket charges that they are aware of.

You are responsible for knowing your benefits. We will do our best to provide information on your insurance coverage, but we cannot guarantee the accuracy of this information or of services covered under your plan. Your insurance will make a determination when the claim is processed. If you have questions about your coverage, please call the member number on your insurance card for clarification.

I understand that I am responsible for providing current information on my medical and vision insurance and my contact information before or during my visit, for obtaining timely referrals from my PCP if necessary, and for any charges that are not covered by my insurance, or which my insurance determines are patient responsibility.

Name (please print) _____ Signature _____

Date _____

Staff Initials_____