

Lowell Eye Care

PAYMENT POLICY

1) Professional Fees:

- a. All fees for professional services are due in full the day services are rendered. If you are utilizing medical insurance or a vision plan for part of the payment, all estimated copayments and overages and deductibles are due on the date of service. We will submit claims for you. However, we are not liable for collecting your claim. Your insurance is a contract between you and your insurance company, not between Advanced Eye Care of Grand Rapids, PLC DBA Northview Eyecare and the insurance company. Acceptance of insurance assignment by this office does not absolve you of your responsibility for the charges for the treatment rendered. An estimate will be given to you at the end of your office visit to be used as a guideline until the final insurance payment is received, and your account has been reconciled. We can make no guarantees of the insurance payment. If your insurance does not pay for a procedure or informs us that your copayment is more than what we had initially charged at the time of your visit, you are responsible for payment in full. If there are any discrepancies, please contact your insurance company and/or employer's benefit department. You are ultimately responsible for any charges incurred in the office. After 30 days, we will expect payment in full if your insurance company or vision plan has not paid. There will be an interest rate of 1.5% applied to unpaid balances upon each statement after the initial invoice. If the account defaults and as a result is sent to a collection agency, a 40% collection rate will be applied to outstanding invoices.
- b. During the performance of a comprehensive eye examination, certain medical eye conditions may be revealed that deserve special attention. I understand that there are specific coverage limitations with my vision care plan and that Advanced Eye Care DBA Northview Eyecare's contract with the vision care plan does not cover medical eye care services. In this event, my medical plan will be billed, and I understand I will be responsible for any applicable copays, cost-shares and/or deductibles. I also understand that Northview Eyecare will not neglect medical findings to bill my vision plan, as that would put Northview Eyecare in direct conflict with its ethical obligations to the Michigan State Board of Optometry.

2) Missed appointments and late cancellation may be subject to a fee, this fee will be charged at the doctors' discretion.

3) Fees for eyewear are as follows:

- a. For those patients with no vision plans – a minimum of one-half down to order and balance due in full on the day of dispensing the eyewear.
- b. Patients utilizing a vision plan – all co-payments and overages are due in full prior to ordering eyewear.

4) Fees for contact lenses are as follows:

- a. Patients with no vision plan must pay their entire professional and material fee prior to ordering.

- b. Patients with vision plans must pay all co-payments and overages prior to ordering.
- c. Telephone replacement orders must be paid for in full prior to ordering. We accept credit card payments over the phone.

5) Refunds:

- a. We do not offer refunds on glasses orders or professional services. Glasses are custom made to your prescription and cannot be utilized for another patient.
- b. Unopened boxes of contact lenses may be returned for partial credit towards additional contact lenses if the prescription has changed. Partial credit will be 70% of the original fee.
- c. Custom made contact lenses cannot be returned or refunded. Custom contact lenses are made to your prescription and cannot be utilized for another patient.

Our collection policy is designed for you, our valued patient. In order for our office to continue to render the quality service and products to which you are accustomed, these policies are necessary and have been ordered by our management consultant and accountant.

I HAVE READ AND AGREE TO THE PAYMENT POLICIES STATED ABOVE.

Signature _____ Date _____

Print Name _____

I acknowledge that I have legal rights to my prescription and that I can obtain my prescription within my patient portal.

Signature _____ Date _____