Puget Sound Eye Care
Payment Policy

1. You are responsible for charges for the services provided even if you have the right to be reimbursed by an insurance company or other third party. We will provide a courtesy billing to your insurance as a service to you. Any balances not covered by your insurance will be billed when we are notified that it is your responsibility. However, if your insurance company has not paid within 60 days from the date of service, you will receive a statement and the remaining balance will then be your responsibility. If you still feel your insurance should pay, it will be your responsibility to contact them. Any past due balances (those requiring a second statement) will be charged interest at the rate of 1.5% per month in addition to a $15 statement fee.

2. If you wish to have your insurance billed, we require a copy of your insurance card or the company's full name, address, phone number, policy identification number and group number. Without this information, we will be unable to verify benefits or bill your insurance and payment is due from you at the time of your visit.

3. Any co-payments or non-covered services are due at the time of service.

4. All co-payments and non-covered amounts not collected at the time of service, and that are acknowledged prior to leaving the office will have a $15 statement fee added, the patient will be responsible for ALL charges including the statement fee.

5. All insurance payment quotes from this office (including those for exams, contact lenses and glasses) are ESTIMATES based upon information provided by you and your insurance company. FINAL DETERMINATION IS NOT MADE UNTIL AFTER THE CLAIM IS SUBMITTED AND PROCESSED BY YOUR INSURANCE COMPANY. Puget Sound Eye Care is not responsible should your insurance pay less then expected.

6. Payment for the services provided to you might require a referral from your primary care provider or insurance company. You are responsible for obtaining this referral. If payment is denied because of a lack of a referral, you will be required to pay for the charges or obtain a retroactive referral for the services.

7. In the event that a medical condition is detected, diagnosed, treated or needs to be addressed during the eye evaluation, your medical insurance may be billed.

I understand that any co-payments; deductibles or non-covered amounts are due at the time of service. I understand that all non-covered charges and co-pays not paid at the time of service, and that result in a statement will be subject to a $15 statement fee. Further, I understand that any quotes of insurance coverage benefits are estimates and I will be financially responsible for any balances not covered by my insurance. I understand that I am responsible for obtaining any referrals necessary for the services required. I also understand that both my vision and medical insurances may be billed should the need arise.

I have read and understand all the payment policies of Puget Sound Eye Care. I authorize the release of medical information necessary to process all insurance claims, including Medicare and its agents. I am financially responsible for any balance due. If this account is sent to a collection agency, I agree to pay all associated collection fees.

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Patient Name

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Signature of Patient or Legal Guardian Date