

Thank you for choosing Berks Eye for your eye care needs. We are committed to providing you with quality and affordable eye care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it prior to any treatment, ask us any question you may have and sign in the space provided. A copy will be provided to you upon request.

**FULL PAYMENT IS EXPECTED AT THE TIME OF SERVICE.  
WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, AMERICAN EXPRESS AND DISCOVER.**

### **INSURANCE/CLAIMS SUBMISSION:**

Your insurance policy is a contract between you and your insurance company. Any balance billing you receive for the services provided is your responsibility. When you give us the correct information, we submit claims to the insurance companies we participate with and will assist you in any way we reasonably can to help get your claims paid. Please be aware that some and perhaps all, of the services provided may be non-covered services according to your policy. You are responsible for paying for non-covered services. All co-payments and/or refraction fees must be paid at the time of service. If you are covered by an HMO (Health Management Organization) you are required to have a referral from your Primary Care Physician at the time medical service is provided. It is your responsibility to contact your Primary Care Physician. If you do not have a referral, you will be billed for the services. If you were involved in a motor vehicle accident, please have your claim number and address where the claim should be mailed. If this is a worker's compensation claim, please make certain we are on the panel of physicians at your workplace. We must have the claim number and address where the claim should be mailed.

### **UCR (USUAL CUSTOMARY REIMBURSEMENT):**

You are responsible for payment regardless of the amount your insurance company approves. We accept UCR amounts from insurance carriers with whom we contract. The patient is responsible for deductibles, co-insurance or non-covered services as indicated by your carrier contract.

### **MINOR PATIENTS (UNDER 18 YEARS OF AGE):**

The parent or guardian accompanying a minor child is responsible for full payment. If both parents have insurance, the parent with the first birthday in the year is usually the primary insurer. **Before your appointment**, please check your insurance policy to determine which company is primary. In divorce cases, we will bill the participation insurances. The parent who seeks medical treatment for their child will be the responsible party unless a copy of the court order showing legal liability is presented.

### **OPTICAL SERVICES:**

Full payment of eyewear is required at the time most glasses are ordered. For all vision insurance eyewear orders, the total cost is due at the time of order placement. Our Contact Lens Coordinator will detail contact lens charges and payment schedules. Entire balance due must be paid for eyewear or contact lenses to be dispensed. All paid or partially paid optical or contact lens orders must be picked up within 60 days of patient notification they are ready for pick up. If not picked up by patient within 60 days, the order will be cancelled and patient deposit not refunded.

### **BILLING:**

A billing statement will be mailed monthly. Payment for all medical services is due 14 days from the date of the invoice. All statements which go unpaid 45 days from the due date will automatically be assessed a \$30.00 service fee and assigned for legal recovery to a professional collection agency/attorney. Please speak to our Practice Manager if you have a financial hardship. A payment plan is available.

### **COLLECTION BALANCES:**

If you had a previous collection balance, are presently in collections or have a past due patient balance over 90 days, most often full payment is required before any new office visits will be scheduled. If you are unable to pay your outstanding balance, you will be referred to the nearest hospital emergency room or ophthalmology free clinic for your eye care.

### **MISSED APPOINTMENTS**

Appointments that are not cancelled 24 hours prior are subject to a \$25.00 charge. This charge is not covered by insurance and is the responsibility of the patient. This policy may be waived when circumstances warrant.

To indicate that you have read and understand this payment policy, please sign and date below.