CARLSSON
Pediatric & Family Eye Center

FINANCIAL POLICY

The goal of Carlsson Pediatric and Family Eye Center is to provide the best possible eye health and vision care with high quality products. In an effort to keep the costs of this down, Carlsson Pediatric and Family Eye Center has established this financial policy. It is your responsibility to pay at the time of service. We accept cash and checks, as well as Visa, MasterCard, and debit cards for your convenience.
All returned checks are subject to a $25.00 NSF fee and a $10.00 reprocessing fee.
All prescription eyeglasses are considered to be **Custom Orders and are not refundable**. We have a **NO cancellation policy** because these orders are custom made per person, per prescription. These orders are processed electronically the same day ordered and can not be stopped. Please choose your purchase wisely and consider the advice of our trained professionals.

We will gladly bill the primary vision and medical insurance carriers with whom we have a contract as a courtesy to you. We are unable to bill secondary insurance. If we are not contracted with your insurance company we will provide you with the information needed to bill your primary and secondary insurance. In order for us to bill your insurance we must be provided with a copy of your insurance card at the time of service showing the member's name, ID and group numbers, as well as the claims billing address. Any information that is not provided on the card is the patient's responsibility. We will not bill your insurance after 30 days from the date of service. If you provide us with incorrect insurance information we will not re-bill after 30 days from the date of service. Because every insurance plan is different, we recommend you contact your insurance company prior to your appointment to verify eligibility and plan coverage. Medical claims may require a referral from your primary care physician (PCP). It is your responsibility to contact your PCP. Carlsson Pediatric and Family Eye Center can not accept responsibility for knowing your insurance coverage, collecting from the insurance company or negotiating settlements on a disputed claim.
If time allows and we are able to reach your insurance company we would be happy to verify your vision coverage. The covered amounts given over the phone or internet from your insurance company are an estimate only. Any difference is your responsibility.

You are ultimately responsible for your account regardless of your insurance coverage. Carlsson Pediatric and Family Eye Center's total usual and customary fees will be itemized for you. The estimated fees are due at the time of service. Any difference between the estimated amount you pay and the amount the insurance actually pays is also your responsibility. Please remember that insurance coverage is typically a defined benefit and is not intended to cover the cost of examinations or optical products in full.
A billing fee of $25.00 will be assessed monthly on any amount due after 60 days. After 120 days, any outstanding balance will be turned over to a collection agency for payment. At that time, a 35% processing fee will be assessed.

I, _____ have read and understood this policy.
Please print name.

_____ Date _____
Signature of Patient or Legal Guardian (if minor)

Medicare Patients Only: Medicare # _____
Please note: Examination fees are due at the time of service
Medicare Patient/Guardian Signature: _____ Date: _____