NORTHERN VALLEY
Eye Care INC.

802-524-9561
Fax: 802-524-6060
www.nveyecare.net

128 Fisher Pond Road
St. Albans, VT 05478

Steven J. St. Marie, O.D.
Laura L. Werner, O.D.

FINANCIAL POLICY

Thank you for choosing Northern Valley Eye Care, Inc. as your eye health care provider. We are committed to providing you with high quality lifetime optometric care so that you may fully attain optimum vision and eye health. Everyone benefits when office and financial policy arrangements are understood. In order that we may have a definite understanding in regard to the payment for Optometric services, the following is our policy:

Payment is due at the time service is provided. We accept cash, personal checks, cashier's checks, money orders, Visa, Mastercard, Discover and Care Credit. Returned checks will be subject to additional fees. We do understand extenuating circumstances may occasionally cause financial hardship. Please call or speak directly to our Office Administrator to discuss a reasonable payment agreement.

Patients who carry eye care insurance understand that all eye care services furnished are charged directly to the patient and that he or she is personally responsible for payment of all optometric services regardless of eye care insurance. As a courtesy to you we will help you process all your insurance claims for insurances in which we are participating providers. We ask that you pay the deductible and co-payment, which is the **estimated** amount not covered by your insurance company at the time we provide service to you. We must emphasize that this is only an **estimate** and all charges you incur are your responsibility regardless of your insurance coverage. Insurance companies have a wide variety of rules, plan limitations and exclusions that our office may not be aware of. Eye care insurance is most commonly a benefit for the patient provided by their employer and such contracts lie between the patient, employer and the insurance company. Our office is not a party to that contract. We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. However, this office will not enter into a dispute with your insurance company over any claim. Once insurance has paid their share, a statement will be sent to you for any remaining balance and will be due upon receipt. If your insurance company has not made payment within 60 days, the unpaid balance becomes your responsibility and is subject to finance charges and the collection process.

Under your health plan, (Ie: MVP, Medicare, Tricare, BCBS, Cigna and other commercial insurances) you are personally financially responsible for co-payments, co-insurance, and deductibles for covered services, as well as those services that exceed benefit limits. You are also financially responsible for all non-covered services as defined by your health plan contract. Non-covered services may include (but are not limited to) refraction (92015), supplies, vitamins, or Durable Medical Equipment.

Separated & Divorced Couples with Dependent Children: It is the policy of this office to bill the parent that brings the children in for their eye care treatment. Please make arrangements for payment from an ex-spouse before eye care treatment is rendered. We can provide a treatment cost estimate before your scheduled appointment.

All Patients must provide an **ID Card** & **Insurance Card** (if applicable) to be copied at the time of the appointment. We also require home and work telephone numbers, as well as a contact number to use in case of emergency.

Broken Appointment Policy: We have more patients who need our services than we can accommodate in our daily schedule. While everyone's needs are important, some patients are in more urgent need of our timely care than others. To best ensure that you and our other patients receive necessary care in a more timely fashion, we employ a Broken Appointment Policy. **A Broken Appointment is any of the following:**

- Missing a scheduled appointment without providing at least 24-hours advance notice.
- Rescheduling your appointment with less than 24-hours advance notice.
- Arriving late such that your appointment needs to be rescheduled.

Our office charges $50 per Broken Appointment. We appreciate life's challenges and second chances. We will waive one Broken Appointment charge per household, provided there is no 90-day overdue back balance. Beyond that, our policy stands. **Patients with 3 Broken Appointments will be limited to our Call List for Same-Day Appointments.** Our Call List is entirely subject to schedule

availability. Although we will document Broken Appointments for our internal use, we assume no responsibility or obligation to notify you of your Broken Appointment history.
If you think that you will be late for your appointment, please call as soon as possible so that we may advise you if we can accommodate your appointment or if we'll need to reschedule it. An answering machine is available so messages can be left after business hours. Should you need to reschedule or cancel your appointment, kindly call us at least 24-hours before the appointed time so we may offer it to another.

Referrals: Should our doctors decide that you need to be seen by a specialist, it is your responsibility to check with your insurance carrier to determine if a REFERRAL or PRIOR AUTHORIZATION is required. There are numerous levels of coverage and policy requirements for each carrier/insurance company. We will help you and your provider process the referral; however, our staff is not responsible for knowing whether or not your policy has these requirements.

We thank you for the opportunity to serve your eye health and vision care needs and welcome any questions you may have concerning your care or our policies. *Significant costs are incurred in carrying our patients' accounts. To control these costs and help keep fees down, it is necessary to adhere to these policies.*

CONSENT: I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY EYE CARE BENEFITS DIRECTLY TO MY OPTOMETRIC OFFICE. The undersigned hereby authorizes Doctor to conduct tests, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's Optometric needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Optometric Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. I further understand that a finance, rebilling, collection charge or attorney fee will be added to any overdue balance.

Printed (Legible) Patient's Name

Signature of Insured/Responsible Representative Date

Printed (Legible) Full Name of Insured/Responsible Representative

Witness Date

☐ Patient (name printed above) was given a copy of form but would not sign.

Witness Date