Parkland Eye & Vision

Your Family Vision Source

Financial Policy

Payment

Payment is due in full at time of service. We accept cash, check, Visa and MasterCard.

- Payment for all prescription devices, lenses, contact lenses and materials must be made ***before*** orders are placed.
- Orders are processed at time of full payment.
- Order cancellations must be made before close of that business day. Cancellations after this time are subject to charges.
- Account balances over 30 days will receive a finance charge of 1.0% per month (12% APR).
- Checks returned for insufficient funds will incur a fee of $40 in addition to the amount due.
- Accounts not paid in full within 90 days are automatically placed with an outside collections agency

Insurance

Parkland Eye & Vision is not responsible for charges NOT covered by your insurance company.

- Insurance cards must be presented along with necessary forms at time of appointment.
- We cannot guarantee the accuracy of information given by insurance companies regarding coverage.
- It is the patient's responsibility to determine whether insurance company covers services rendered.
- We will bill your insurance if we are a participating provider for your program.
- We may bill your vision, medical insurance or multiple plans depending on coverage policies and your vision or medical condition(s).
- If we are not a participating provider, upon payment at time of service, you will be provided with paperwork to submit to your insurance company for reimbursement.
- You will be billed for all charges not reimbursed by your insurance company.
- Deductibles, co-payments and non- covered professional services or materials are due at the time of service or when materials are ordered.

I understand that I am responsible for the balance on my account for services rendered and/or materials purchased.
If delinquent balances are referred for collection, I agree to pay all costs and attorney's fees.
I authorize that my insurance payments are paid directly to Parkland Eye & Vision.
I authorize use of this signature on all insurance claims.
I also authorize release of records to my insurance company as needed.

I have read and agree to the Financial Policy of Parkland Eye & Vision Clinic, PLLC.
This agreement remains in effect until revoked by me with written notification to
Parkland Eye & Vision Clinic, PLLC.

____________________________________ **Signature**

____________________________________ **Print Patient Name**

Relationship to Patient (Please Circle)   Self   Parent   Guardian

Date _____ __________________