ASHBAKER VISION CLINIC FINANCIAL POLICY

All fees will be collected the day of your examination; this includes all co-pays, fees for ordering contacts and/or glasses, as well as balances insurance will not cover. As a courtesy, we will file your insurance claim on your behalf; however, you or your legal guardian are responsible for payment in full no later than 30 days after services have been rendered.

Using past payments as an example or a telephone call to your insurance company, we can estimate your fees. We work with your insurance company on your behalf, but are not their employee. If you have two insurances and one "might pay", we will not file a claim to "see if they will pay", as that will delay our timely payment. If you have two insurances that will pay, one as primary and the other as secondary, we still expect payment in a timely manner, which is defined in the state of Washington as 30 days.

Should we get paid by your insurance company after receiving your payment, we will reimburse you the amount of payment we received from your insurance company. Should the payment on the balance of the account be delayed longer than 30 days, the account may be charged at the rate of 12% per annum (which is 1% per month), but will be charged a $5.00 re-billing fee. Billing statements will be sent out approximately every 30 days.

We accept Cash, Visa, Master Card, and Personal Checks. Non-Sufficient funds checks will be charged up to $40.00 but will not exceed the face value of the check. We reserve the right to charge $25.00 for appointments broken 24 hours or less before the scheduled time. Should we be able to fill that appointment time, the fee will be dismissed. Order for glasses and/or contacts will be processed when at least 50% of the total cost is paid. We will dispense your glasses and or contacts when your balance is paid in full. When a year worth of contacts have been ordered and paid for in full, they can be shipped directly to your home.

INSURANCE NOTE

We will check coverage and file your insurance for you, however, insurance in an agreement between you and your insurance company. *Occasionally, insurance carriers will deny procedures or reimbursements they have verbally approved, saying they are "not indicated", "not a covered procedure", or "not covered without a referral".* We expect all benefit information to be confirmed by the patient. We are not responsible for any denied claim for any reason; however, we will reasonably assist you in claim authenticity and preliminary filing. You are responsible for your fees whether you have insurance or not. We will accept your payment today for your services and/or hardware (glasses and/or contacts) with Visa, Master Card, Cash or Personal Check, whichever works best for you today.

I understand and agree to the financial policies outlined above. Date: ____/____/________

Printed Name: ____________________________ Signature: ________________________________

I will be paying for today's services and products not covered by my insurance today with:

Please Circle: Cash Visa Master Card Personal Check

My balance in full will be due 30 days from today which is the ___________ of

Jan Feb March April May June July Aug Sept Oct Nov Dec

REFUSAL TO FILL THIS FORM OUT IN FULL RELEASES THIS CLINIC FROM PROVIDING CARE