

## OFFICE FINANCIAL POLICIES

This information has been prepared for your benefit. It contains our policies regarding insurance, billing, and payment of services.

**Please read and initial each statement.**

Harmon Vision Center will file claims for primary and secondary insurance. Co-payments, charges for non-covered services and deductibles are **due in full at the time of service.** \_\_\_\_\_

It is your responsibility to be aware of and follow your insurance restrictions and/or guidelines. If your insurance requires a referral you are responsible for obtaining that referral. If your insurance requires you to select a physician from a list of providers, it is your responsibility to schedule your appointment with a provider on that list. Employees of Harmon Vision Center cannot guarantee this information for you. You must use the information provided by your insurance company. \_\_\_\_\_

Harmon Vision Center does NOT file claims to automobile or liability insurance. All charges are due at the time of service and the patient will be provided with the information they need to file a claim and receive any reimbursement directly from the insurance company. \_\_\_\_\_

Harmon Vision Center will follow up on unpaid insurance claims. However, your policy is an agreement between you and your insurance company and it is your responsibility to assure that your services here are paid. \_\_\_\_\_

Adult or teenage children, who present for treatment, or to pick up eyeglasses or contact lenses, but whose parents are assuming financial responsibility, must arrive with proper insurance information and be prepared to pay for non-covered services. \_\_\_\_\_

**Patients must provide us with current insurance information or the account will be the responsibility of the patient.** This information would include the name of the routine vision plan. You need to be aware of your coverage and provide us with the correct information. \_\_\_\_\_

**Routine vision plans** cannot be filed for any patient being seen with a **medical eye condition** (i.e., cataracts, glaucoma, macular degeneration, foreign-body removal, red eyes, eye pain, itching or burning, or any eye problem not normally corrected by lenses). **Routine vision plans are strictly for a well eye exam** and do not apply if you have ever been diagnosed with a medical eye condition or complaints that might lead to a medical diagnosis. \_\_\_\_\_

Many insurance companies consider a refraction to be a non-covered service. Refraction is the test necessary to determine if you had a change in your vision and might need a new prescription for glasses or contacts. You are responsible for payment of the refraction if your insurance does not cover it. \_\_\_\_\_

Social Security numbers are a necessary part of your financial information with our office. This information, as with any of your medical record, is protected with strict confidentiality. You are asking us to extend you credit by filing insurance for your charges and not collecting in full at the time of service, therefore we must have this information or all charges must be paid at the time of service. \_\_\_\_\_

Your signature indicates that you have read the above financial policy and understand your obligations.

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Patient's Signature or parent if patient is a minor

Date