BILLING POLICIES

ABOUT OUR FEES.....

We participate with many carriers and accept assignment from many others, but please remember... **it is your insurance coverage, not ours, and you are responsible for** providing sufficient billing information as well as determining if my services are covered under your plan. The patient is always primarily liable for our charges.

If we participate with your insurer, and a referral is necessary, it is the patient's responsibility to insure that a valid referral is in effect at the time of treatment – if not, the patient is financially responsible for services rendered.

In the event that we do not participate with your insurer, you are responsible for all fees pertaining to your treatment in this office. We will, however, continue to work with you to help you obtain reimbursement from your carrier if possible.

To keep you aware of the status of your account, the office will send you a monthly statement which details charges and payments made to your account for the last thirty days. Any amount appearing on the "Total balance due line" are your responsibility and should be remitted promptly.

Should your private insurance company pay you directly for doctor bills incurred, it is your responsibility to forward that money to this office. If you keep this money, we will consider this "theft of services" and pursue it to the fullest extent of the law.

ALL co-pays are required to be paid at the time of your office visit. There is a Five Dollar ($5.00) service charge added to a patients account if their co-pay is not paid at the time of their office visit. Also, should your account become delinquent and placed with a collection agency and or lawyer for payment, the patient will be responsible for any additional fees for services charged by the collection agency, lawyer fees. Any checks with insufficient funds will incur a Thirty Dollar ($30.00) fee.

The patient will also receive a Twenty-five ($25.00) Dollar charge added to your account for any and all missed appointments for which we do not receive adequate notice/or which are not re-scheduled within 24 hours.

Sincerely,

Amherst Eyecare/Kenmore Eyecare, Inc.

I have read the above policy and agree to abide by the terms established in this form,

Patient's Signature_____ Date_____

Please provide your E-Mail Address for our records.

E-MAIL ADDRESS: _____

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