Capital Vision Center PC
603-226-0855
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Financial Policy

153 Manchester St.
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This is an agreement between the doctors of Capital Vision Center PC, and the Patient/Debtor named on the form.

In this agreement the words "you," "your," and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to the doctors of Capital Vision Center PC.

By executing this agreement, you are agreeing to pay for all services that are received.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, if any, and any payments or credits applied to you account during the month.

Payment options if you have no insurance:

1. You may choose to pay by cash, check, or credit card (Visa, Mastercard, or Discover) on the day that services are rendered.
2. Regarding orders for glasses or contact lenses: you may choose to pay (1) the order in full at time of order, or (2) 50% on the order date and the remaining balance upon pick up.

Payment options if you have insurance:

1. You may choose to pay your deductible and any out-of-pocket portions at the time services are rendered by cash, check, or credit card.
2. You may choose to pay all of your treatment by cash, check, or credit card. We will request your insurance carrier to send their payment directly to you.
3. Regarding orders for glasses or contact lenses: you may choose to pay (1) the order in full at time of order, or (2) 50% on the order date and the remaining balance upon pick up.

Restocking Fee: In the event that you cancel an order for custom items (which would include all glasses and/or specialty contact lenses), if the job has already been started by the lab, you will be responsible for a restocking fee of **50%** of the entire custom order.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid within **20 days** of the statement date.

Late Fee: A late fee of **$20.00** will be added to your balance each month (**30 days**) the account is past due.

Required payments: Any co-payments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we cannot bill you for these.

Refunds: Refunds will be given in the same form as the original payment. If the original cash payment was over $20.00, the refund will be given in the form of a check. All refunds will be processed and mailed within 30 days.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits or orders would then need to be paid in full at the time of service or when the order is placed.

Contracted Insurance: If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay, you must pay that at the time of service. It is the insurance company that makes the final determination of your eligibility. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company. We will not be responsible for reimbursement of a lower insurance payment in this circumstance.

Non-contracted Insurance: Insurance is a contract between you and your insurance company. We are **not** a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what

your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company. We will not be responsible for reimbursement of a lower insurance payment in this circumstance.

Returned checks: Checks returned unpaid will be electronically collected by CCR along with all fees and expenses allowable according to state laws. Currently, the fee for any checks returned by the bank is **$30.00.**

Missed appointment fee: We request that patients give **24 hours notice** for canceling an appointment. Those who fail to do so twice within a **6 month** period will be asked to pay a **Missed Appointment Fee of $75.00** for their exam or visit upon scheduling for the 3rd time. This fee must be paid before a new appointment is scheduled and will be credited towards their exam or visit at the time of service. The Missed Appointment Fee **cannot** be used on materials (including but not limited to contact lenses or glasses) in lieu of an exam or visit and is non-transferable. Any overage will either be applied to other services, outstanding balances, materials, or refunded back to the patient in the original form of payment within 30 days. If the patient is not seen within 30 days of paying the fee, it will **not** be refunded and cannot be applied to any future balances on services or materials.

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer's fees which we incur plus all court costs. In case of suit, you agree the venue shall be Merrimack County, New Hampshire.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Transferring of Records: You will need to request in writing, and pay a reasonable copying fee if you want to have copies of your records for yourself, or sent to another doctor or organization. Charges for medical records are **$1.00** for the 1st page and **$0.50 for each additional page.** As a courtesy to you, our office will not charge for the first 10 pages, but will begin charging on the 11th page. Th amount of the fee is dependent on the number of pages we need to copy. The charge for copies of photographs or images will be **$2.50 per page.** You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Worker's Compensation: We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full. If no written approval/authorization is received prior to your initial visit, you will be asked to pay in full at the time of service. We will still bill your worker's compensation carrier as a courtesy to you, but will request reimbursement to be sent directly to you.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we request payment in full at the time of service. We **cannot** bill your attorney for charges incurred due to a personal injury case.

Effective Date: By signing this financial policy, you agree to all of the terms and conditions herein and the agreement will be in full force and effect.

I authorize the release of any information necessary to process insurance claims.
I am aware of the financial policy of Capital Vision Center PC.

Patient's Name:(Please print clearly)_____

Authorized Signature:_____ Date:_____