LODESTAR
FAMILY EYE CARE, PC

Financial Policy

Patient name (please print):_____

Our goal is to provide the very best and most complete, up-to-date care available. Our philosophy is preventive and developmental in approach. To provide this service in the most efficient manner, please be aware of the following office policies:

- Insurance coverage is not a guarantee of payment
- We will bill your insurance as a courtesy if you present your insurance card(s) at the time of your appointment. Any patient responsibility (deductibles, copays, coinsurance) must be paid at the time of service.
- You will receive a statement for any remaining balance after all applicable insurance(s) have been billed. That balance will be due in full at that time or you are welcome to contact our billing office to set up payment arrangements.
- We accept cash, check, VISA, MasterCard, Discover, and American Express credit cards, as well as CareCredit. Payment in full at the time of service is required in the following circumstances:
    - You are a self-pay patient (payment arrangements can be set up if you are not able to pay in full at time of service).
    - You have not brought your insurance card(s) with you.
    - You have not met your deductible.
- A 50% deposit is required at the time of ordering products.
- We reserve the right to charge for any missed appointment that is not cancelled in advance. We require 24 hour notice for rescheduling/cancelling appointments. A $25.75 fee may be applied after reasonable discretion.
- Balances left unpaid for more than 90 days may result in finance charges, being sent to collections, and/or termination from care at Lodestar Family Eye Care, PC. Any and all delinquent charges must be paid in full before you may receive further care at our office.
- The Veterans Administration, by law, requires Lodestar Family Eye Care to submit claims to private insurance if available. Patients insured by the Veterans Administration are required to provide us with private insurance information prior to being seen.

By my signature below, I acknowledge that I have read and that I understand the above statements and am willing to accept responsibility to pay for services rendered if my insurance does not cover them. This authorization is not limited in time.

Patient signature:_____ Date:_____