Patient name (please print): ____

Financial Policy

Our goal is to provide the very best and most complete care available. 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, but any patient responsibility (deductibles, copays, co-insurance) 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 upon receipt
- We accept cash, check, major credit cards, as well as CareCredit & PayPal.
- We require 24-hour notice for rescheduling or cancelling appointments. A $25 - $75 fee may be applied for any missed appointment that is not cancelled in advance.
- Balances left unpaid may result in 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 receiving further care at our office.
- The Veterans Administration, by law, requires Lodestar Family Eye Care, PC 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
- Frames and lenses are custom made to your specific needs and prescription, and therefore are non-refundable. Please see our warranty card for further information.
- A 50% deposit is required for the ordering of frames, lenses or contact lenses.

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/Guardian Signature: ______________________________ **Date:** ____________________

Agreement to Receive Electronic Communications

- I agree that Lodestar Family Eye Care PC may communicate with me electronically at the contact information I have provided.
- I am aware that there is some level of risk that third parties might be able to read unencrypted emails.
- I am responsible for providing Lodestar Family Eye Care updates to my contact information.
- I may withdraw my consent to electronic communications at any time by calling 907.745.2273.

Patient/Guardian Signature: ______________________________ **Date:** ____________________