LODESTAR
FAMILY EYE CARE, PC

Financial Policy

Patient name (please print): _____

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:

- Vision and/or medical insurance coverage is not a guaranteed form 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. Additionally, if for any reason your insurance company denies payment or does not pay in full, you are then fully responsible for any remaining balance. Services rendered and custom optical purchases are non-refundable.
- Any and all specialty testing performed to diagnose or manage eye diseases are separate billable fees to your medical insurance provider. You are responsible for any copay, deductible and/or co-insurance amount. Fees are available upon request.
- 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.
- A 50% deposit is required for the ordering of frames, lenses or contact lenses.
- We accept cash, check, major credit cards and CareCredit.
- Any and all delinquent charges must be paid in full before receiving further care at our office.
- Balances left unpaid may result in being sent to collections, and/or termination from care at Lodestar Family Eye Care, PC.
- Refunds will be processed using original of payment.
- We require 24-hour notice for rescheduling or cancelling appointments. A $75 fee may be applied for any missed appointment that is not cancelled in advance.
- The Veterans Administration 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.

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. This authorization is not limited in time.

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.

Signature: _____ Date: _____

If you are signing as a personal representative of the patient, please describe your relationship to the patient and the source of authority to sign this form.

Print Name: _____ Relationship: _____ Source of Authority: _____