LODESTAR
FAMILY EYE CARE, PC

Financial Policy

Patient name (please print): _____

Our goal is to provide the best and most complete care available. To provide this service in the most efficient manner, please be aware of the following office policies:

- Payment is expected at the time of service for treatment performed that day unless prior arrangements have been made. For your convenience, we accept cash, checks, major credit cards, and CareCredit.
- We will file an insurance claim on your behalf as a courtesy to you; however, you must supply, prior to the appointment, all the necessary information for filing.
- Any deductible as well as any estimated percentages your insurance does not cover, are to be paid on the date of treatment.
- It is the patient's responsibility to know the details of the insurance coverage, including percentages payable, waiting periods, deductibles, yearly maximums, services not covered under the plan, and any other related information.
- Not all services are a covered benefit. Some insurance companies arbitrarily select certain services they will not cover. While the filing of insurance claims is a courtesy that we extend to patients, all charges are your responsibility from the date the services are rendered.
- Balances left unpaid may result in being sent to collections, and/or termination from care at Lodestar Family Eye Care, PC.
- Services rendered in optical are highly customized and are **Non-Refundable,** and cannot be cancelled once we have placed your order. **We take no responsibility and assume no liability for glasses and contacts ordered online.**
- We require a 50% deposit for ordering frames, lenses and contact lenses.
- If you cannot keep your appointment, a 24-hour notice for rescheduling or cancelling appointments is required. A $75 fee may be applied for any missed appointment that is not cancelled in advance.

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: _____