FINANCIAL POLICY

Sign this copy for you records in our office. Payment is due when services are provided. We accept cash, checks, and VISA, Mastercard, Discover or American Express.

You may have health insurance that may pay a portion of your bill. As a courtesy to you we will file you claim if we are a Participating Provider for your insurance plan. We participate with most insurance carriers. Please call our insurance department for more information. (757)-595-8404.

You are responsible at the time of your visit for:
* Co-payments
* $35.00 Refraction charge when paid at time of service
* Contact lenses fitting fee
* Supply of contacts lenses

*** At your first appointment and at some future visits, part of your exam will be to determine your best vision, with correction if necessary. This is a refraction and consists of testing your vision by looking at an eye chart through lenses that can be changed to assist you to see as clearly as possible. This diagnostic test assists the doctors in determining if you might have any disorders or eye diseases causing a decrease in vision or if your vision can be corrected by a prescription for glasses. For most insurance companies including Medicare and Tricare, a refraction is a non-covered service which you must pay in addition to any co-pays at the time of service. **Failure to pay the refraction fee of $35.00 at the time of service incurs an additional $15.00 billing fee.**

We do not charge for copies of your written glasses prescription which you may have at any time if you have had a refraction in the last year. We try to give our patients a new prescription at least once a year even if there is no change in their vision. This allows you to have a current prescription in the event you break your glasses, purchase an extra pair, or add or replace sunglasses.

Returned check charges are $25.00. If it becomes necessary to place your account with a Collection Agency, you may have additional charges added to your account.

I have read and understand the above policy.

_____ Signature of patient/Responsible party

_____ Date