Wallis Family Eyecare
Our Financial Policy for Medical Insurance

Dear Patient:

Thank you for choosing us as your healthcare provider. The following is our Financial Policy. Our main concern is that you receive the proper and optimal treatment. Therefore, if you have any questions or concerns about our payment policies, our team will be happy to address them. We ask that all patients read and sign our Financial Policy as well as complete our Patient Information Form prior to seeing our doctors. A copy will be provided to you upon request.

For those who have medical insurance:

1. **Co-payments and deductibles.** All co-payments and deductibles are due at the time of service. When you make a payment, you will pay an estimate of the expected patient responsibility. When your insurance company notifies us of your patient responsibility, we will either send you a statement for the rest of the balance due or issue you a refund check.

2. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Please be aware that the balance of your claim is your responsibility. Not all services are covered benefits or you may be Out-of-Network. You can contact your insurance company to confirm if your provider is in Network. If your insurance company does not pay your claim in 45 days, the rest of the balance will automatically be billed to you. We will ask that you contact your insurance carrier to inquire as to why the claim has not been paid.

3. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. Any services not covered due to changes in insurance coverage will be the patient's responsibility.

Our practice is committed to providing the best treatment to our patients. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns. Again, thank you for choosing us as your healthcare provider.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Print Patient Name (if under 18 years old, Parent/Guardian) Date

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Patient Signature (if under 18 years old, Parent/Guardian)