



NORTHERN VALLEY
Eyecare INC.

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FINANCIAL POLICY

Thank you for choosing Northern Valley Eyecare, Inc. as your eye health care provider. We are committed to providing you with high quality lifetime optometric care so that you may fully attain optimum vision and eye health. Everyone benefits when office and financial policy arrangements are understood. In order that we may have a definite understanding in regard to the payment for Optometric services, the following is our policy:

Payment is due at the time service is provided. We accept cash, personal checks, cashier's checks, money orders, Visa, MasterCard, Discover and Care Credit. Returned checks will be subject to additional fees. We do understand extenuating circumstances may occasionally cause financial hardship. Please call or speak directly to our Office Administrator to discuss a reasonable payment agreement.

Patients who carry eye care insurance understand that all eye care services furnished are charged directly to the patient and that he or she is personally responsible for payment of all optometric services regardless of eye care insurance. As a courtesy to you we will help you process all your insurance claims for insurances in which we are participating providers. We ask that you pay the deductible and co-payment, which is the **estimated** amount not covered by your insurance company at the time we provide service to you. We must emphasize that this is only an **estimate** and all charges you incur are your responsibility regardless of your insurance coverage. Insurance companies have a wide variety of rules, plan limitations and exclusions that our office may not be aware of. Eye care insurance is most commonly a benefit for the patient provided by their employer and such contracts lie between the patient, employer and the insurance company. Our office is not a party to that contract. We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. However, this office will not enter into a dispute with your insurance company over any claim. Once insurance has paid their share, a statement will be sent to you for any remaining balance and will be due upon receipt. If your insurance company has not made payment within 60 days, the unpaid balance becomes your responsibility and is subject to finance charges and the collection process.

Separated & Divorced Couples with Dependent Children: It is the policy of this office to bill the parent that brings the children in for their eye care treatment. Please make arrangements for payment from an ex-spouse before eye care treatment is rendered. We can provide a treatment cost estimate before your scheduled appointment.

All Patients must provide an ID card & Insurance Card (if applicable) to be copied at the time of the appointment. We also require home and work telephone numbers, as well as a contact number to use in case of emergency.

Cancellation & Late Policy: Your appointment time is reserved for you. If you are late for your appointment, we may not be able to accommodate you. If you think that you will be late, please call as soon as possible so that we may advise you if your late arrival can be accommodated, or if we will need to reschedule you. We maintain a very high demand patient schedule and must insist that appointment times be respected. For cancellations we require 24 hours advanced notice. An answering machine is available for messages left after business hours. **We will grace each patient with one unannounced missed or "no show" appointment as we appreciate life challenges and second chances. Beyond that, we will charge a \$50.00 fee for appointments missed or cancelled with less than 24 hours notice.** Although we will document unannounced missed appointments for our internal use, we do not assume any responsibility to notify you of your missed appointment history. Any combination of (3) unannounced missed or "no show" appointments per household will result in discharge from the Northern Valley Eyecare, Inc. practice.

Referrals: Should our doctors decide that you need to be seen by a specialist, it is your responsibility to check with your insurance carrier to determine if a REFERRAL or PRIOR AUTHORIZATION is required. There are numerous levels of coverage and policy requirements within each carrier/company. We will help you and your provider process the referral; however our staff is not responsible for knowing whether or not your policy has these requirements.

We thank you for the opportunity to serve your eye health and vision care needs and welcome any questions you may have concerning your care or our policies. *Significant costs are incurred in carrying our patients' accounts. To control these costs and help keep fees down, it is necessary to adhere to these policies.*

CONSENT: I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY EYE CARE BENEFITS DIRECTLY TO MY OPTOMETRIC OFFICE. The undersigned hereby authorizes Doctor to conduct tests, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's Optometric needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Optometric Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. I further understand that a finance, rebilling, collection charge or attorney fee will be added to any overdue balance.

Printed (Legible) Patient's Name

Signature of Insured/Responsible Representative

Date

Printed (Legible) Full Name of Insured/Responsible Representative

Witness

Date

Patient (name printed above) was given a copy of form, but would not sign.

Witness

Date

FOR OFFICE USE ONLY

Unannounced missed appointment:

Witness:

Date: