NeuroSight Vision Care
Drs. Kerry Jarvis, Regina Chonka & Paul Kersjes
550 South Wadsworth Boulevard, Ste. 415, Lakewood, CO 80226
Phone: 303-989-2020 Fax: 844-875-0149

FINANCIAL POLICY AND AGREEMENT

Welcome! Thank you for selecting us as your health care providers. Our goal is to provide you and your family with optimal medical care. We want you to feel welcome and comfortable as possible throughout our relationship. We encourage you to ask questions and to be involved in treatment decisions. This includes understanding your treatment plan as well as our financial policy.

Patients are expected to pay for our services at the time they are rendered & before you leave our office. Payments may be made by cash, check, or using most major credit cards.

EYEGLASSES, CONTACT LENSES, LOW VISION OR OTHER MATERIALS

If you request that we order eyeglasses, contact lenses, or other items for you, these items should be paid in full or all exam services and 50% deposit on the day that we place the order for you. We cannot order or dispense these items to you until we have received your full payment. These items are custom made products that are unique to your particular visual correction and they are not returnable.

INSURANCE AND MEDICARE

We accept most major medical and vision insurance plans. You must provide us with your current insurance information and a photocopy of your insurance identification/Medicare card. Please verify your coverage with your insurance company. As a convenience to you, we will bill your insurance company directly, but on the day of your visit you are responsible for paying your co-pay, deductible, overage, co-insurance, and any other amounts not anticipated to be covered by your insurance plan. Please note that Medicare does not cover routine eye examinations not related to a medical condition, refraction for your prescription eyeglasses, contact lenses, medications, or special testing.

OUT OF NETWORK INSURANCE

Where we are not in-network with your insurance plan, you are responsible for full payment of all goods and services on the day of your appointment. We will provide you with the necessary forms so that you can file a claim with insurance company for reimbursement.

PAST DUE ACCOUNTS

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. In the event your account remains unpaid for more than 90 days, your account may be referred to a third party collection agency. You will be responsible for fees, costs, and expenses of up to 30% of our invoiced amount if your account is referred to a collection agency.

We must emphasize that as eye care professionals, our relationship is with you and not your insurance company. You are ultimately responsible for all fees for both services and materials delivered to you by our office. Our practice is committed to providing the best treatment to our patients.

I have read, understand and agree to the Financial Polices Statement above.

Signature of Patient or Responsible Party Patient's Name Date