

Low Country Vision Center

We are committed to providing you with the best possible care. In order to do this, we need your assistance and your understanding of our payment policy:

1. Payment/co-pay's are due **at the time services are rendered**. We accept cash, checks, Visa, MasterCard or American Express. Returned checks are subject to a \$30 fee. If you are self pay, how will you be paying today?

_____ Cash _____ Check _____ Visa/Mastercard/American Express

2. Filing of insurance claims is a courtesy we extend to our patients; **all fees are ultimately the patient's responsibility to pay**. As a participating provider in certain insurance networks, we will bill your primary and secondary insurance carriers in these networks.

3. **If your insurance plan requires a referral/or authorization** (from your primary care physician) to go to a specialist, the patient needs to provide our office with this information on the day services are rendered.

4. Your insurance is a contract between **you, your employer, and/or insurance company**. We are **NOT** a party to that contract or any other third party (i.e. Attorney and/or liability insurance carrier).

5. **Not all services are a covered benefit in all insurance contracts**. The patient will be responsible to pay for those services.

6. After **NINETY DAYS**, if no payment has been received, the patient or responsible party will be required to make payments on the account.

7. **All Returns and cancellations are as follows: Prescription Lenses are subject to a 50% service charge, all other returns or cancellations are subject to a 20% Service Charge. No Exceptions.**

If a financial problem should arise, we encourage you to contact us promptly for assistance in management of your account.

I have read and understand the office policy stated above and agree to accept responsibility as described.

Patient's Signature (Parent, If minor)

Date

Print Full Name