Corona Optique

AYuma=s Most Progressive Optical Shop@

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Financial Policy

As is customary, professional fees are due at the time services are rendered.

Regrettably, we are unable to carry accounts longer than 60 days. In the event that you have failed to pay for the services and materials provided by this office, and the account is placed for collection, you understand and agree that an additional amount equal to 40% of the balance owing at the time the account is placed for collection, will be added to the current balance owing. In addition to a collection fee of 40% of the balance owed, I agree to pay interest at the rate of (10%) ten percent per annum until the amount owed is paid in full.

Non sufficient checks will be charged an additional $30.00 bank fee.

Insurance Policy

Insurance co-payments and/or deductible amounts are due at the time services are rendered.

If we are unable to assist you in verifying your insurance coverage or eligibility, any co-payments and/or deductibles amounts will be due at the time of the initial service. Any balances not paid by the insurance company will be billed to the patient. Payment is expected upon receipt of statement.

There are many vision plans available to our patients through various insurance companies. Many of these companies frequently change their coverage=s and their policies. Despite our best efforts, we are unaware of all the provisions of each plan.

Your insurance coverage is a contract between you and your insurance company. We will gladly bill them on your behalf. However we cannot guarantee payment of your claim. If we are unable to collect payment from your insurance company or they deny your coverage you will be responsible for the balance. **We do not bill secondary insurances.**

Fees

Comprehensive Vision Examination - $94.00
Contact Lens Examination Starting at- $124.00 - $184.00
Office Visit for Eye Injury or Illness - Minimum $49.00 *Average visit is $69.00*
*(Except for Medicare and Blue Cross Blue Shield most likely **not** covered by your medical insurance.)*

Signature of Patient_____Date_____

Save:financialpolicy