CORONA OPTIQUE
2149 W. 24TH STREET
YUMA, ARIZONA 85364

Financial Policy

As is customary, professional fees and co-pays are due at the time services are rendered. A copayment may apply if an illness is evaluated or procedure is performed during the annual Vision Exam.

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 collection charge. 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.

TELEPHONE CONSUMER PROTECTION ACT ("TCPA") REGULATIONS

You agree, in order for us to service your account or to collect any amounts you may owe, we and our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to us.

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. You are responsible for any balance your insurance does not pay, or any authorization given by your insurance and later denied. Your insurance coverage is a contract between you and your insurance company. We will bill them on your behalf. We cannot guarantee payment of your claim. _____Please initial**

Medicare will not cover the refraction fee. You acknowledge that this is a non-covered charge and will pay the $10.00 charge.
We do not bill secondary insurances. _____Please initial

Fees

_____ **Comprehensive Vision Examination** - $109.00-119.00. Pediatric follow up exams when seen three months after the initial exam will be at no charge. Follow up exams scheduled at six months will be charged a $25 refraction fee.
_____**Contact Lens Examination** Starting at- $139.00. Includes three follow up appointments within 90 days at no additional charge. Follow up exams scheduled after three appointments or 90 days, will be charged $25.00 per visit.
_____**Office Visit for Eye Injury or Illness** - Minimum $99.00 per visit.

Signature of Patient_____Date_____