VIRGINIA EYE CONSULTANTS FINANCIAL POLICY

Thank you for choosing VEC as your eye health care provider. We are committed to your successful treatment. Please understand that payment of your bill is considered a part of your treatment.

Self pay or non-covered services are due in full at time of service. WE ACCEPT CASH, CHECKS, AND ALL MAJOR CREDIT CARDS.

_________INSURANCE
VEC will file insurance claims as a courtesy to our patients. This includes Medicare, Anthem, as well as any commercial plans we participate with. Please remember that your insurance is a contract between you and your insurance company. All co-pays and deductibles are due at the time of treatment. It is the patient's responsibility to update VEC when there are any insurance changes, failure to do so will result in the patient being billed for 100% of the service charge.

There will be a service charge equal to your co-pay if it is not paid at the time of service. There will be a $35 fee for all returned checks. The patient will be responsible for any collection/attorney/court fees, if applicable, associated with collecting the physician's fee. There will be a 1.5% monthly service charge on unpaid balances.

_________AUTHORIZATION
I hereby authorize my insurance company, (Medicare or any other Commercial or Government Insurance) to reimburse my VEC physician directly, realizing that I am responsible to pay non-covered services and I hereby authorize the release of pertinent medical information to my insurance carrier.

_________USUAL AND CUSTOMARY RATES
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. Generally you will be responsible for payment regardless of any insurance company's arbitrary determined of usual and customary rates.

_________MINOR PATIENTS
The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan.

X____________________________________DATE___________________________
Signature of Patient or Responsible Party

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