Children's Eye Clinic, P.C.
Financial Policy

Child's Name:_____ **Date of Birth**_____

As a specialty clinic, we only participate with your medical insurance. Many of the children we see in our clinic are seen for medical exams and this is billed to your medical insurance only. ***We do not participate with any vision plans***.

Until your child's exam is completed, we will not be able to determine the diagnosis. This diagnosis determines whether the exam will be routine or medical. ***It is up to you to call your insurance company to verify the benefit for a routine or medical eye exam and the refraction procedure.***

REFRACTION: This is a standard part of our exam. It is how the physician determines whether your child will need glasses. It is a non-covered service by most insurance companies**.** ***We will collect the refraction, if your medical insurance does not cover this procedure.***

High Deductible Plans:	The Clinic will collect half of the total bill.
For a Co-pay Plan:	The Clinic will collect the specialty fee.
Routine Exams:	The Clinic will collect in full.
No Insurance Card: (At the time of visit)	The Clinic will collect in full.

We will collect the above fees at the time of your child's visit.

Please put your initials here _____ that you understand our collection policies.
If you have any questions, please call before your appointment.

It is your responsibility to pay any fees to this office for services regardless of your benefit limitations.

Our clinic is not a party to any separation or divorce decrees. The parent bringing the child to the exam is responsible for any fees due. The office will not split billing between the parents.

Benefit Assignment Authorization

I authorize the release of information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf and I assign the benefits payable to which I am entitled to Children's Eye Clinic, P.C. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original document.

I certify that I have read and fully understand and accept the above financial policy.

Print Name of Parent/Guardian: _____

Signature of Parent or Guardian:_____

Relationship to Child:_____ Date Completed:_____

UPDATED: 03/20/15