Financial Policy

___ Payment is due when services are rendered and a deposit is required on all eyeglasses and contact lenses that are ordered. Outstanding balances must be paid in full to receive contact lenses and/or eyewear.

___ If we are a participating provider for your insurance plan, please give the necessary information to our receptionist. Payment is required for any deductibles, co-pays or non-covered balances at the time services are provided and before any materials are ordered.

___ It is your responsibility to understand your insurance policy and coverage. We are happy to assist you in insurance billing matters if requested, but all plans are different and our office cannot know all details of your particular plan. Should your insurance company pay differently than was determined at the time of your visit you are still responsible for any outstanding balance on your account.

___ Regardless of what your insurance provider says during the predetermination process, coverage is not guaranteed. Should your insurance company fail to pay any or all claims for your services or materials 45 days from the date the initial claim is filed, you agree to aid with the collection of this fee from the insurance company. If for any reason the insurance company denies payment, you are responsible for any balance that remains, and agree to pay the bill upon receipt. If the account has to be turned over to our collection company for non-payment, you understand there is a 35% collection fee assessed to your account.

___ If our office is not filing insurance for you, payment in full is due at the time of service.

___ Although we know that emergencies do arise, we ask for at least 24 hours' notice for all cancellations. Telephone messages can be left 24 hours a day, 7 days a week. If you do not show up to a scheduled appointment, or fail to cancel it ahead of time, a $35.00 charge will apply. This charge is not billable to insurance, and is the responsibility of the patient/guardian.

___ As a courtesy, we try to confirm your upcoming appointments 1 day in advance. However, circumstances do not always allow us to reach you. Please do not count on a reminder call as your only source of remembering your appointment. If you have questions about your scheduled appointment, please call our office.

I have read and understand the above information. In addition, I hereby authorize Dr. Lisa B. Dibler to furnish my insurance carriers with any information required concerning my condition and treatments. I understand that I am responsible for any amount not covered by my insurance. Upon notification that my insurance will not cover all or part of the fees, I hereby authorize Dr. Dibler's office to charge the following credit card for the total fees due:

Method of Payment: _____Visa / MC / Amex/Discover

Card Number: _____ Expiration Date: _____

Signature_____Date_____

Print Name: _____ Name of Patient: _____

Name of Person Responsible for Payment: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Best times to call: _____