DESERT VIEW EYE CARE FINANCIAL POLICY

FULL PAYMENT IS DUE AT TIME OF SERVICE – IF INSURANCE IS BILLED CO-PAYMENT AND/OR DEDUCTIBLE IS DUE AT TIME OF SERVICE. ***GLASSES AND CONTACT LENSES MUST BE PAID IN FULL BEFORE THEY ARE ORDERED.***

CONTACT LENS EVALUATION

- Contact lens evaluation and fitting fees range from $45.00 - $80.00 or higher depending on what type of evaluation is performed.

OPTOMAP RETINAL SCREENING

- The out of pocket copay is $25.00 for adults and $15.00 for children.

REGARDING INSURANCE & UCR (Usual & Customary Rates):

- You are responsible for payments regardless of your insurance company's arbitrary determination of "usual and customary' rates. Your insurance policy is a contract between ***you and your insurance company***. Any disagreement you have concerning the amount your insurance pays should be directed to your insurance company.

DIVORCE

- In case of divorce, Desert View Eye Care is not party to the divorce settlement. The person signing this agreement is responsible for any and all payments for services. Any disagreement between two parties of a divorce must be dealt with between those parties and ***DOES NOT*** involve Desert View Eye Care.

PAST DUE ACCOUNT

- If Desert View Eye Care refers your account to a collection agency, you will be charged reimbursement fees of any collection agency, which may be based on a percentage at a maximum of 50% of the debt, and all costs and expenses, including reasonable attorney's fees Desert View Eye Care incurs in such collection efforts.

RETURNED CHECKS

- There is a fee ***(currently $25.00)*** for any checks returned by the bank.

CANCELLED ORDERS

- When you order glasses or contacts, the order goes out electronically that same day. If you choose to cancel after that, there will be a cancelation fee per the lab.

INTEREST FEE

- If insurance is billed then co-payment and /or deductible is due at the time of service unless prior approval is received from our office. As of July 1, 2014 Desert View Eye Care will charge ***1.5 % INTEREST PER MONTH*** or ***an ANNUAL PERCENTAGE RATE of 18%*** on any outstanding balance over 60 days.

BY MY SIGNATURE BELOW, I HEREBY AGREE TO AND UNDERSTAND DESERT VIEW EYE CARE'S FINANCIAL POLICY AS STATED ABOVE.

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Signature (Patient or Responsible Party) Date