

**JERVEY EYE GROUP, P.A. – JERVEY EYE CENTER**  
Patient Responsibility Payment Policy

*Thank you for choosing our practice. We are committed to providing the best possible care. The following information is provided to avoid any confusion regarding payment for our professional services. Please sign below that you have read and agree to this Policy.*

PLEASE PRESENT INSURANCE CARD AT THE TIME OF VISIT.

Payment Policy

- We accept cash, check, Visa, Master Card, Discover and American Express.
- At the time of your visit, you are responsible for paying your co-pay, refraction fee and any deductible not met. If these charges are not paid on the date of service, a \$25.00 fee may be added to your account.
- Your insurance company requires us to collect your copays and deductibles.
- All fees are based on the type of service provided for your care, diagnosis (medical vs. routine vision care) and related services. Many insurance plans make a distinction between routine vision exams (for glasses/contacts only and no medical problems or diagnoses) and medical eye exams (medical complaints and/or diagnoses.) It is your responsibility to know what is covered by your insurance. **We must file each visit based on both the reason a patient is seen and any diagnoses made at the exam.**
- If the patient is a minor (18 years old and younger), the parent or guardian is responsible for payment of the account in accordance with the policies outlined above. If parents are divorced, the adult who brings the child to the appointment is responsible for applicable fees.
- For any cosmetic or noncovered surgical services, payment for all charges is due at time of service.
- Payment for any contact lens fitting is due at the time of service. We will file your insurance and refund to you any money received.
- If your account is more than 90-days overdue, it will be considered delinquent. If you write a check and it is returned, a \$30 collection fee will be added to your account.
- For High Deductible policies (including patients with Health Savings Accounts), payment will be collected at the time of service and any contracted discount fees will apply.
- A \$25.00 charge will be applied to your account when you miss the first “confirmed” appointment.

Insurance

As a courtesy, we will file your insurance. However, it is your responsibility to know your benefits, to notify this office of any changes to your insurance coverage, and to pay any amount that is determined to be your responsibility. If we are unable to verify your insurance for coverage or authorization for services, you will be responsible for any charges incurred. Your insurance policy is a contract between you and your insurance company. We are not a party to this contract. If your insurer has not paid within 45 days from filing, you will be billed for the entire amount even if the claim is being appealed. If an appeal is necessary, we will appeal your claim one time only. **It is your responsibility to contact your insurance company if payment has not been made, although we will help provide any information required from our office.**

Acknowledgement and Authorization

I have read, understand and agree to the above Payment Policy. I understand that any charges not covered by my insurance company are my responsibility.

I authorize my insurance benefits be paid directly to Jervey Eye Group, P.A. and/or Jervey Eye Center.

I authorize Jervey Eye Group, P.A. and/or Jervey Eye Center to release any medical or other information to my insurance company when requested.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name