Eye Land Optometry

1150 E Artesia Blvd, Long Beach, CA 90805

Financial Policy

Payment

Full payment is due at time of service. We accept cash, Visa, MC, or Discover. Please be prepared to show picture identification such as a driver's license.

Insurance

Are you aware of what your insurance covers? We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company; we are not a party to that contract.

Some or all services and material provided to you may not be covered as “reasonable and necessary” under the Medi-Cal (Section 1862 a1), Medicare, and/or other medical insurances. The balance is your responsibility whether your insurance company pays or not.

If your insurance company has not paid your account in full within 60 days, as required by state law, the balance will be automatically transferred to you. Billed charges are due upon receipt.

Regarding insurance plans where we are a participating provider, all co-pays and deductibles are due the day of service. In the event that your insurance coverage changes to a plan where we are not participating providers, you are responsible for the charges.

Discounts applied to services and material cannot be combined with billing an insurance plan.

Patients who are minors **(under 18 years old)**

The parent or guardian accompanying a minor is responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit card or payment is made by cash or check.

Non Refundable Materials **(including glasses, contact lenses, low vision devices)**

All prescription optical materials are customized and fabricated specifically for each individual patient. Fees for these materials are non-refundable, and once ordered, become the financial responsibility of the patient. All materials not picked up after 90 days become property of Eye Land Optometry.

Missed Appointments

Please help us serve you better by keeping scheduled appointments or calling us in advance (at lease 24 hours) to reschedule an appointment.

Delinquent accounts

We reserve the right to charge interest and/or late fees on past due balances (in the amount of 18% as provided by state law). There will be a $39 service charge for any returned checks. Cash, money order, or a credit card will then be required for payment.

By signing below, I acknowledge that I have read and / or received a copy of Eye Land Optometry’s Financial Policy.

_____ _____

Signature Date

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Professional Service Policies

Our follow up visits are intended to assess the quality of each patient's vision with the new contact lenses. We also determine if the patient is experiencing any adverse physiological changes secondary to wearing new contact lenses. Each patient is required to return with the contact lenses on, within one to two weeks of dispensing the contacts. If a follow up appointment is not completed within 60 days of the original exam date, the patient will be required to pay an additional $25 fee for the late follow up visit.

If a final contact lens and/or glasses prescription is released, any additional follow up visit after 60 days will be $25 per visit.

There are **NO REFUNDS** for professional services rendered.

Signature Authorization
I request payment of authorized medical insurance benefits be made either by myself, or on my behalf for any services furnished me by the staff and doctors affiliated with Eye Land Optometry or to any party which accepts assignment. **I understand that I am responsible for any procedures not covered by my insurance company for any reason. I understand that I am responsible for any co-payments, deductibles and /or contact lens fittings.**

I authorize the release of any medical information to the authorized third party necessary to process claims for services rendered.

I acknowledge that all information in my medical records is confidential and will be handled only by the associates of Eye Land Optometry.

I understand that all professional fees are NON-REFUNDABLE

HIPPA Privacy Acknowledgment of Notice of Privacy Practices

I acknowledge that I have read and /or received a copy of Eye Land Optometry's Notice of Privacy Practices, Professional Service Policies and Signature Authorization

Patient Name_____ Date_____

Signature_____