ZEIFERT EYE CARE FINANCIAL POLICY

Thank you for choosing Zeifert Eye Care for your eye care needs. We are committed to providing the best possible individualized care for each of our patients. The following is the office policy, and is provided to avoid any misunderstanding regarding payment for professional services and materials.
Our office accepts most medical insurance plans and associated vision benefits (commonly called eye insurance). It is the patient's responsibility to know the requirements and details of your policy. Some services may not be covered under your plan, and will be your responsibility. We are happy to help answer questions about your insurance; for us to verify benefits we need this information at least 24 hours before your appointment. If you have specific coverage concerns, please reach out to the customer service department of your insurance company. We are required to verify your identity when you utilize insurance; for this reason we will ask for a state issued picture ID, such as a driver's license.

CONTRACTED IN NETWORK MEDICAL PLANS AND VISION PLANS

Prior to your visit, you should confirm with your insurance plan that our optometrists are participating (in network) providers. It is the guarantor's responsibility to understand their insurance benefits and requirements.
Copayment/Coinsurance is due at time of service.

DEDUCTIBLES

If my insurance determines that I have not met my deductible, I understand that I will be fully responsible for payment in a timely manner, no more than 30 days after I have been notified by insurance and/or provider. Yearly deductibles cannot be waived at any time by Zeifert Eye Care.

NON-CONTRACTED MEDICAL PLANS

We are not in network for HMO, Medicaid or Medicaid replacement plans. In this case, payment is due at the time of service in full. We accept cash, checks and credit cards.

MEDICARE

We are in network with Medicare, we will file the claim with Medicare; and Medicare will forward the claim to all secondary insurance companies. You must provide us with the secondary/supplemental insurance information before your visit. Any unpaid or non-covered services will then be billed to the patient.

INSURANCE AND PAYMENT

Not all insurance plans pay the same benefit or utilize the same deductible amounts; there are many different plans under each insurance plan and these can all change each year. ***Our office accepts both medical insurance and vision benefits (vision benefits commonly go under another name such as VSP, Eyemed, Spectera or Davis); if you are using a vision benefit we need you to provide us with the following: policy holder's name, date of birth, and social security number. We need this information before the exam in order to verify you are eligible. If it is not provided, we will bill your medical insurance or you will be self pay. We can not backdate, or switch insurance after the exam has been completed***. There may be a balance due after your insurance company has paid their portion. *It is essential that the guarantor provide the correct information* (full name, DOB, address, and insurance info) for filling the claim, and notify us of any changes. Failure to provide the office with the correct patient information may result in an insurance claim denial; in this case, you agree to be responsible for the charges in full. We will bill your insurance company on your behalf; but you are ultimately responsible for the charges. You agree to be responsible for all non-covered services by your insurance plan.

Patient Initials _____

NO SHOW OR LAST MINUTE CANCELLATIONS

I understand that if I do not show up for a scheduled appointment or cancel less than 24 hours in advance, I will be charged a $50 fee.

Patient Initials_____

PAST DUE BALANCE

After insurance has paid their portion, you may receive a bill. We appreciate prompt payment, accounts past 90 days will be sent to a collection agency. If there is an extenuating circumstance, please reach out to our office to discuss other options.

Our practice provides the care each patient needs. We are happy to answer any questions regarding insurance and financial policies; please reach out to our office manager with any concerns or questions.
I have read and understand the financial policies above. By signing below, I am agreeing to comply with these policies.

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PRINT PATIENT NAME GUARANTOR/PATIENT SIGNATURE

GLASSES/MATERIAL POLICY

I understand that I am responsible for 100% of all materials at the time materials are ordered. If I am supplying my own frame, I understand that many plastic and metal products may weaken over time and I will not hold Zeifert Eye Care or my insurance carrier responsible for accidental laboratory breakage. If I do not pick up my materials within 60 days from my initial order, my materials will be returned to the laboratory, and my payment will not be refunded. Glasses are custom made, and orders can not be canceled once the lab has started fabricating the lenses. No refunds will be given once the glasses order has been started.

CONTACT LENSES

If I am to receive contact lenses by mail, I understand that I am required to pay in full at time of service. We will exchange (not refund) unopened, unmarked, non-expired boxes of contacts that are in re-sellable condition; this is only for contacts that were originally purchased at Zeifert Eye Care.

Our Patient Satisfaction Guarantee applies to single vision and progressive lenses. We use only premium single vision optics and premium progressive addition lenses, otherwise known as no line bifocals. Less than one percent of our patients have difficulty adapting to our premium progressive lenses. We will remake a non-adapt progressive lens or single vision lenses one time, in the same frame. If it is still unsatisfactory, we will replace it with a lined bifocal or a single vision lens, in the same frame. While we make every attempt to solve these rare issues, no refunds will be given in a case where a patient does not adapt to a progressive lens or single vision lens.

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GUARANTOR/PATIENT SIGNATURE

HIPAA

I understand that under the Health Insurance Portability ACT of 1996 (HIPAA), which I have been provided with a copy, that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly, obtain payment from third party payers, and conduct normal healthcare operations such as quality assessments and physician certifications.

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GUARANTOR/PATIENT SIGNATURE