GLEN ELLYN VISION CENTER
ELGIN VISION CENTER
FINANCIAL POLICY

The Glen Ellyn Vision Center/Elgin Vision Center is committed to providing you and your family with the best care possible. This goal is best achieved if everyone is aware of the financial policy, which is an agreement between the doctors of the practice and the Patient or guardian. Your clear understanding of the financial policy agreement is important to our professional relationship.

- I acknowledge that I am fully responsible for all costs incurred during my treatment at The Glen Ellyn Vision Center/Elgin Vision Center.
- I acknowledge that payment is due at the time of service.
- I understand that as a courtesy, The Glen Ellyn Vision Center/Elgin Vision Center will file my insurance claims on my behalf, but they do require a copy of my current insurance card to insure accurate information for processing.
- I understand that although The Glen Ellyn Vision Center/Elgin Vision Center will try to pre-authorize services and materials prior to the visit, insurance plans vary considerably, and we cannot predict or guarantee what part of our services will or will not be covered.
- I understand that my insurance is a contract between me and the insurance company. The Glen Ellyn Vision Center/Elgin Vision Center is not a party to that contract. If my insurance company does not pay within 30 days of submission, I will be responsible for payment of the charges incurred.
- I agree to pay The Glen Ellyn Vision Center/Elgin Vision Center (in full) within 30 days of notification of nonpayment by my insurance carrier. If after 30 days we have not received payment, and there is a credit card on file with The Glen Ellyn Vision Center/Elgin Vision Center, I understand that it will be charged for the entire amount due and a receipt will be mailed to me.
- I understand that I will be responsible for services deemed "not medically necessary" by my insurance company.
- Parents and guardians are responsible for full payment on unaccompanied minors.
- I agree that payment of insurance benefits be made on my behalf to the Glen Ellyn Vision Center/Elgin Vision Center for any services furnished me by the Glen Ellyn Vision Center/Elgin Vision Center.
- I understand that a collection agency may be used to collect unpaid balances. I further agree to pay any and all legal and collection costs incurred on my account.
- I understand there is a $39 service fee for all returned checks. At that time my account will be placed on a cash or credit card only basis.
- I understand that any appointment canceled within 24 hours of the appointment time will be charged $25.00. Any appointment missed with no call will be required to leave a $25 deposit in order to schedule the next appointment.

If there are any questions concerning your bill, please do not hesitate to ask. Your signature indicates that you have read, understand, and agree to all of the above policies. As a responsible party, your signature indicates acceptance of the aforementioned policies and authorizations.

Signature: _____ Date: _____

Printed Name: _____ Relationship to Patient: _____

Patient Name (if different than above): _____