Financial Policy

The Glen Ellyn 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 understand that I am responsible for all costs incurred during my visit at The Glen Ellyn Vision Center.
- I understand that payment is due at the time of service.
- I understand that parents and guardians are responsible for payment in full on unaccompanied minors.
- I understand that although The Glen Ellyn Vision Center will try to pre-authorize services and materials prior to my visit, insurance plans vary considerably, and we cannot predict or guarantee what part(s) of our services will or will not be covered.
- I understand that my insurance is a contract between myself and the insurance company. The Glen Ellyn 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 understand that I will be responsible for services deemed "not medically necessary" by my insurance company.
- I understand that The Glen Ellyn Vision requires that a credit card be kept on file. If I choose not to provide a credit card, I understand that The Glen Ellyn Vision Center will submit only to my vision insurance and that the cost for any/all other services or materials will be due in full at the time of service.
- I understand that The Glen Ellyn Vision Center will provide me with a statement of any balance remaining after insurance claims are resolved in order to provide me with the option to change my payment method.
- I understand that 30 days after the aforementioned statement date, the credit card on file with The Glen Ellyn Vision Center will be charged for the entire amount due and a receipt will be mailed to me.
- 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 appointments cancelled, rescheduled or missed with no call within 24 hours of the scheduled 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 below indicates that you have read, understand, and agree to all of the above policies.
As a responsible party your signature below indicates acceptance of the aforementioned policies.

_____ / _____
(Print Patient / Responsible Party Name) (If Minor, Print Patient Name)

_____ / _____ / _____
(Credit Card Holder Name) (Card Last 4) (Card Exp. Date)

Please provide the front desk with your credit card so that it can be entered into our secure/encrypted system.

☐ I DECLINE keeping a credit card on file and understand that only my vision insurance will be billed and/or that the cost for any/all services or materials will be due in full at the time of service.

Signature: _____ Date: _____