1300 South Canfield Niles Rd
Austintown, OH 44515-4081
T:(330)792-9900 F:(330) 953-0778
PattersonsEyecare.com

FINANCIAL POLICY & DISCLOSURE

I assign of all of my medical benefits to Dr. Jeffrey R Patterson O.D. &/or Dr. Justin R Patterson O.D., of DR PATTERSON'S FAMILY EYECARE and authorize said assignee to release all information necessary to secure payment from my insurance company. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company, and that final determination can only be made when the claim is processed. As such, I understand that if some fees are not paid by my insurance, I am still responsible and will be billed for them. Accounts 90 days-old are subject to collections, and there will be a service charge for any bounced checks. In order to control billing costs and reduce the need to raise our fees, all co-payments, deductibles, and charges for non-covered services, as per your insurance contract, are due at the time that they are rendered.

NOTICE OF EXCLUSION FROM HEALTH PLAN BENEFITS

SELF PAY - You will be required to pay in full the same day that services are provided, at check out. Methods of acceptable payments are cash, local bank check, CareCredit, or major credit/debit cards. In order to provide the best medical care, we ask that you do not discuss your financial concerns with the physican(s) or medical staff. Please discuss account information at front desk.

DIVOCE/CUSTODY POLICIES- The parent/guardian who brings the patient into our office will be held financially responsible for the minor's expenses, regardless of the provisions in the divorce decree or custody arrangements, and regardless of the child's relationship to the insurance subscriber. For situations where the patient is not able to sign legal documents a personal representative must provide a notorized copy of legal document.

WORKER'S COMPENSATION – If you are a worker's comp patient, it is our policy to bill your employer or the compensation carrier for services rendered. If payment is denied, you will become responsible for the entire balance of your services. Payment will be due within ten (10) days follwing any worker's compensation payment denial. It will be your responsibility to contact us with the name and address of your employer and any insurance that covers the employer.

AUTO/HOME INSURANCE – In the event of an injury/incident occuring that involves an Auto or Home insurance claim, it will be your responsibility to provide our office with the following information: Name and address of insurance covering your claim, name and telephone number of the representative handling your claim, the claim number filed by the insurance company, the date of the injury, and the name and contact information of any legal representation you may have. If payment is denied, you will become responsible for the entire balances of your services. Payment will be due based on either ten (10) days after denial or based on attorney instruction.

PROGRESSIVE LENSES POLICY - Any patient ordering progressive lenses who decides to change the lens to a lined bifocal/single vision after the order is made will not be issued any refunds or the amount difference credited back to them. However, the new change of lens will be provided at no additional charge. Any changes made after 30days are the sole responsibility of the patient-per lens policy.

REFUND POLICY- Regarding the supply of eyeglasses or contacts, we must emphasize that products are ordered to your specifications & are unable to be returned to the manufacturer. If you choose not to pick up your materials after it has been ordered, or within 90 days of delivery to our office, any balance will be turned over to collections. When the balance is paid in full to collections, the materials can then be retrieved from the office.

OVERDUE BALANCES ARE REPORTED TO:
FIDELITY COLLECTION AGENY
220 E Main St, Alliance, OH 44601
(330) 829-6022