BLAHNIK EYE CARE

Financial and Insurance Policy

Thank you for choosing Blahnik Eye Care as your vision care provider. As part of our services, we request you read and sign the following financial policy prior to services being rendered. Patient or responsible party must complete our information and insurance form before seeing Dr. Suzette Blahnik or Dr. Greg Blahnik.

- **Full payment, co-payment, percentages and/or deductibles are due at the time services are rendered.** We accept cash, checks, Visa, MasterCard, American Express, Discover and Debit Cards. If you are purchasing eyewear or contacts, payment is due prior to any order being processed.
- **Office Policy:** Insurance is billed as a courtesy to our patients; however, the patient is the final responsibility party. If your office insurance has not paid within **60 days** you will be notified. Returns or cancellations are made at the discretion of the office administrator and office credit will be issued in lieu of refunds. Please make your selection carefully.
- **Minor Patients (under the age of 18):** The adult accompanying minor (patient/guardian) is responsible for full payment at the time of service. For unaccompanied minors, payment arrangements need to be made in ADVANCE and we must have parents' or guardians' written permission prior to treatment of a minor.
- **Returned Checks:** A $25.00 service charge will be applied to your account for returned checks.
- **Spectacle Prescription:** Patients have 30 days follow-up care from the date of the fitting to make any changes in the prescription necessary.
- **Eye Wear and contact lens prescriptions' that are filled elsewhere are not warranted by Blahnik Eye Care.**
- **Contact Lens Patients:** Additional time and testing is required for fitting and evaluation for contact lenses. Additional professional fees will be applied, and are generally not covered by your insurance company. Patients have 30 days follow-up care from the date of fitting to make any changes in the prescription necessary.
- **Emergency Visits:** There will be a $50.00 fee charged above and beyond the usual customary fees if seen outside of office hours.

Medicare/Medicaid

I request that payment of authorized Medicare benefits be made either to me or on my behalf to the name of provider of service and (or) supplier for any services furnished to me by that provider of service and (or) supplier.
I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related service

Please realize that:

1. **You are responsible for all charges that are denied/not covered by your insurance company.**
2. **Although we verify your coverage through your insurance company with each and every patient, verification of benefits is not a guarantee of payment from your insurance company.**

ACCEPTED MAJOR MEDICAL INSURANCE/LIFETIME INSURANCE AUTHORIZATION SIGNTURE

I request that payment of authorized Primary and Supplement Insurance benefits be made either to me or on my behalf for any service furnished by Drs. Blahnik

I authorize any holder of medical or other information about me to release the Health Care Financing Administration and its agents any information needed to determine these benefits for related services.

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Patient or legally authorized individual signature **Date**
Lifetime Insurance Authorization Signature

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Printed name if signed on behalf of the patient