Financial Agreement

HUNTLEY EYE CARE

11809 East Main Street, Huntley, IL 60142
Phone: (847) 515-2030; Fax: (847) 515-2040
www.huntley-eyecare.com

I **understand** that depending on the nature of my visit and type of service(s) performed, my vision plan and/or medical insurance may be billed, with all applicable co-insurances, co-payments, and deductibles due at time of service.

I **understand** that the nature of my eye complaint, ocular history, medical history, and final diagnosis are the determining factors for deciding whether my vision plan and/or medical insurance is the appropriate party to be billed.

I **understand** my vision plan provides coverage for routine service only (determination of refractive error) and I will be responsible for all co-insurance and co-payments applicable to my vision plan. I **acknowledge** if I have any material benefits I will also be responsible for any additional co-insurance, co-payments, and overage costs towards my material(s).

I **understand** that if I have any medical eye symptoms or if any medical eye problems are detected, screening of those symptoms and/or problems will require further evaluation and management that is only covered by my medical insurance. I **acknowledge** my medical insurance will be the primary party billed for the visit and I will be responsible for all co-insurance, co-payments, and deductibles applicable to my medical insurance.

I **understand** that certain services may not be covered by my vision plan and/or my medical insurance. I **acknowledge** I will be responsible for full payment of these service(s). I **acknowledge** fees for professional services are non-refundable.

I **understand** that co-insurance, co-payments, and deductibles must be collected by Huntley Eye Care, L.L.C. as required by my vision plan and/or medical insurance at the time services are provided.

I **authorize** Huntley Eye Care, L.L.C. to submit claims on my behalf to my vision plan and/or medical insurance for any services and/or products provided.

I **authorize** payment from my vision plan and/or medical insurance to be made directly to Huntley Eye Care, L.L.C. for any services and/or products provided.

I **acknowledge** that Huntley Eye Care, L.L.C. will make reasonable efforts to process my claim for services and/or products provided. However, I **understand** this does not guarantee coverage.

I **understand** my vision plan and/or medical insurance is a contract between me and the company, not between Huntley Eye Care, L.L.C. and the company. I **acknowledge** it is my responsibility to follow up with my vision plan and/or medical insurance for complete coverage details and to ensure that proper coverage and payment has been made on my behalf.

I **acknowledge** that if for any reason payment for services and/or products provided is not paid to Huntley Eye Care, L.L.C. by my vision plan and/or medical insurance, I am ultimately responsible for any and all balance due on these services and/or products.

I **agree** to be financially responsible for all remaining balance on services and/or products not covered by my vision plan and/or medical insurance.

I **understand** that I will be billed for any services and/or products that were denied by my vision plan and/or medical insurance and payment will be expected within 30 days of this bill.

I **acknowledge** that any outstanding accounts over 120 days will be forwarded to a collection agency and all financial matters will then be handled between me and the collection agency unless I have made prior arrangements with Huntley Eye Care, L.L.C.

I **understand** that writing a personal check with insufficient funds is check fraud and that all matters involving check fraud will be referred to the McHenry County District Attorney's office for review and collection. I **acknowledge** a returned check fee of $30.00 will be assessed to me.

I **acknowledge** that there is a 10% service fee if I request to change form of payment for any previously processed credit card payment.

I **understand** that all sales, including prescription lenses, eyeglass frames, sunglasses, contact lenses, and accessories, are final and are not refundable or returnable. I **acknowledge** that there is a 10% restocking fee if I cancel or change any eyewear that has already been processed, provided that the order is able to be cancelled or changed.

Please check ***guarantor*** *(person who will be financially responsible)* for patient's financial account at Huntley Eye Care, L.L.C.

☐ Patient ☐ Spouse ☐ Patient's Mother ☐ Patients' Father ☐ Other _____

Guarantor agrees to assume all financial responsibilities as noted in this agreement for the patient.

_____ _____ _____

Signature of Patient or Guarantor | Print Name of Patient or Guarantor | Date