Parker Vision Specialists, P.C.

9235 Crown Crest Blvd Suite 150
Parker, CO 80138
Ph. 303-840-6268 Fax 303-840-5385

Financial Policy

The following is a statement of our financial policy. ***Please carefully read*** and sign at the bottom.

Routine Exams: We will bill your insurance provided you have routine coverage and are eligible at the time of service. We must have a copy of your card to bill your insurance (except VSP or VCPN). If you cannot provide your card, you must pay for your visit in full at the time of service. If prior authorization or unique claim forms are required, it is your responsibility to obtain this prior to your visit. All co-pays are due at the time of service. *It is your responsibility to know the benefits and coverage requirements of your insurance policy.*

Medical Exams: We must have a copy of your card to bill your insurance. If you cannot provide your card, you must pay for your visit in full at the time of service. If your insurance requires a referral, it is your responsibility to obtain this prior to your visit. If you do not obtain the referral, you will be responsible for all charges. If you require assistance in this, our office may be able to help you. *It is your responsibility to know the benefits and coverage requirements of your insurance policy.*

Optical Orders: We will bill your insurance provided you have optical benefits and are eligible at the time of service. We must have a copy of your card to bill your insurance (except VSP or VCPN). If you cannot provide your card, you must pay for your order in full at the time of service. If prior authorization or unique claim forms are required, it is your responsibility to obtain this prior to your visit. Our policy is to collect at least one half of the balance due for optical orders. The remainder is due upon receipt of your order; an order cannot be released until it is paid in full.

Contact Lenses: Please note that additional services are required that would not be necessary for a normal vision exam. A contact lens exam fee is charged in addition to the normal vision exam fee. *Most insurance companies will not cover this fee.* This fee includes nine months of follow up care with our doctors and is due at the time of service. When possible this fee will be charged to your insurance, but must be charged with a contact lens order.

All co-pays and other balances are due at time of service. After your insurance company has processed our claim, if there is any balance due from you, such as deductible or coinsurance, we will send a statement to you. Balance is due upon receipt of this statement. If payment cannot be made in full within 30 days, please contact our office for a possible payment arrangement. If payment arrangements are not made, you may be sent to a collection agency. Our collection agency will assess finance charges on the balance due. Once the account has been sent to collection, we no longer have control of the account and can no longer discuss details of your account with you.

We will do our best to verify your insurance eligibility and benefits at the time of service. However, a quotation of eligibility and benefits from your insurance company does not guarantee payment. *Please understand that financial responsibility for your account is yours, not your insurance company's.*

An NSF fee of $35 will be assessed for any check returned by the bank.

For your convenience, we accept cash, check, Visa, MasterCard, American Express, Discover and Flex Spending cards. If you are uninsured, full payment is due at the time of service.

I have read, understand and agree to this financial policy.

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Signature of Patient/Guardian Printed Patient Name Date