

Financial Policy Form

Eyes on Burbank Optometry

2005 W. Alameda Ave., Burbank, CA 91506

Phone: 818-476-4639

Financial Policy

Thank you for choosing *Eyes on Burbank Optometry* for your vision care. We are committed to providing quality care and transparency regarding financial matters. Please carefully review our financial policy to understand your responsibilities.

1. Insurance Billing

- *Eyes on Burbank Optometry* accepts a variety of insurance plans and will bill your insurance company on your behalf if we are contracted providers.
- Please be aware that insurance coverage varies, and not all services and products are covered by all insurance plans.
- You are responsible for any co-pays, deductibles, and services not covered by your insurance plan at the time of service.

2. Payment Methods

- Payment for all services not covered by insurance is due at the time of your appointment. We accept cash, debit cards, credit cards, and, if applicable, health savings account (HSA) and flexible spending account (FSA) cards.
- If you require financing, please discuss available options with our staff before your appointment.

3. Non-Covered Services

- Some services or products (such as premium lens options, specialized testing, or contact lens fittings) may not be covered by your insurance. You will be notified of any non-covered services and their costs, and payment will be due at the time of service.

4. Balances and Outstanding Payments

- If you have an outstanding balance, you will receive a statement, and payment is due upon receipt. If you are unable to pay in full, please contact our office to arrange a payment plan.

- Outstanding balances over 90 days may be subject to collection efforts, and additional fees may apply if referred to a collection agency.

5. Returned Checks and Fees

- Returned checks will incur a \$35 fee, and payment of the original balance plus the fee is required immediately.

6. Cancellation and No-Show Policy

- Please provide at least 24 hours' notice if you need to cancel or reschedule your appointment. Failure to do so may result in a cancellation fee of \$50.

Agreement and Acknowledgment

By signing below, I acknowledge that I have read, understood, and agree to the *Eyes on Burbank Optometry* Financial Policy. I understand that I am responsible for payment of all services rendered and any balances not covered by insurance.

Patient Name: _____

Date of Birth: _____

Signature of Patient or Legal Guardian: _____

Date: _____