Brighter Future Vision Clinic PLLC

Patient Name: _____DOB: _____

Financial Policy

If insurance is being billed (medical/vision), your signature below authorizes payment of medical and vision benefits to **Brighter Future Vision Clinic** for services performed.

Please consult your insurance plan for details regarding deductibles and maximum payments. Having insurance is not a substitute for payment. Some procedures and materials that are medical necessary may not be covered by insurance; these services are the responsibility of the patient. Patients are responsible for all charges not paid by insurance, including co-insurance and deductibles. Professional fees are non-refundable. We will assist you in receiving reimbursement as much as possible, but you are responsible in advance for your bill.

All therapy units must be paid for in advance, or a monthly payment policy in place, before therapy can start. If you would like us to bill your unit to insurance, a separate financial agreement must be signed.

- I understand that account balances are due within 30 days of receipt of statement. Overdue accounts are subject to a 1.5% APR finance charge. Account over 60 days will be sent to collections.
- We do accept personal checks. Bounced checks are immediately sent to collections and will be subject to a $25 fee. These fees are separate from fees charged by the collection agency.

By signing below, I acknowledge that I have read and accepted the HIPPA policy. I also acknowledge that the above stated information is correct. Furthermore, I understand the financial policy of Brighter Future Vision Clinic and agree to the terms as stated above.

Signature: _____ Date: _____