Mastrian EYECARE

Financial Policy

Patient Name:_____ DOB:_____

***WITH COVERAGE:**

We cannot bill your insurance company unless you give us **your most recent insurance** information **at the time of your visit.** If you have managed care plan, a co-payment is due at the time of your visit, and must be paid at that time. Payment for any non-covered services is due at the time of your visit. **OUR RELATIONSHIP IS WITH YOU, NOT YOUR INSURANCE COMPANY.**

I understand my obligation to pay any amount not covered by third parties and further agree to pay any amount remaining unpaid by such third parties ninety days after the date of service.

***WITHOUT COVERAGE:**

Since you have **NO** vision insurance coverage, payment in full for your services is due at the time of your visit.

Eyeglass / Contact Lens Customer Agreement:

I understand that it is my responsibility to report any and all problems with eyeglasses/contact lenses within 30 days of my exam to Mastrian Eyecare. Failure to do so will result in loss of warranty and may result in additional fees. Please help us to help you by letting us know as soon as you realize you have a problem. I understand that contact lenses are classified as an FDA controlled medical device that must be evaluated and fit to my unique eye each year, even if you are already a contact lens wearer. Contact lens prescriptions are only valid for 12 months. This is considered a separate medical procedure, therefore, any and all fees for contact lens fitting and evaluations are not included in your routine eye exam.

Patient/Guardian Signature:_____ **Date:**_____