Financial Policy

Thank you for choosing **Desert Valley Eye Care** to meet your eye health needs. We are committed to providing you with the best treatment available. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, of which we require that you read and sign.

PAYMENT IN FULL MAY BE REQUIRED AT THE TIME OF SERVICE

FOR YOUR CONVENIENCE WE ACCEPT CASH, CHECKS, VISA, MASTERCARD AND CARE CREDIT

REGARDING INSURANCE: Your insurance policy is a contract between you and your insurance company. It represents an agreement between you and the insurance company. We are not a party to that contract. We will bill your insurance plan for you, as long as you provide us with the current and accurate information. If we do not have an agreement with your insurance company, that some and perhaps all the services may not be covered services and/or not considered medically necessary under your health insurance plan. You, as the patient, ultimately are responsible for payment of all services provided by our office. Our Patient Accounts department is available to discuss any questions you may have regarding your insurance or your account at (509) 735-2050.

If your insurance plan requires a co-pay, this will be due prior to services being rendered unless you make other arrangements in advance. If while you are under the care of DVEC, your insurance changes in any way, you must inform us before your next visit. If you have a secondary insurance, we will bill it for you, as a courtesy, as long as you have provided us with the current and accurate information.

If you bill any insurance yourself, please do so promptly, so that you will receive reimbursement for the services you have prepaid. We are available at any time to assist you if you need any help with this.

USUAL AND CUSTOMARY RATES: Our practice is committed to providing the best treatment for our patients at the best price possible. You are responsible for the payment regardless of any insurance company's arbitrary determination of usual and customary rates.

MEDICALLY NECESSARY CARE: We will only provide you with a service if we consider it medically necessary. Therefore if your insurance company arbitrarily determines that a service we have rendered to you is unnecessary, you will be responsible for the bill after we have assisted you through the appeal process and after we have exhausted all avenues to have the decision over turned.

CREDIT POLICY: Accounts are due and payable as of the date billed. Unpaid balances will be considered delinquent after 60 days and will result in a $2.50 late fee charge each month until paid in full.

We realize it may be necessary on occasion to arrange installment or other payment programs. If financial problems arise, please contact our Patient Accounts department as soon as possible by calling (509)735-2050.

If an account becomes past due with no valid reason, necessary action will be taken to recover the account balance due.

SELF PAY: We do offer a 25% discount for services only if paid the day services are rendered.

RETURNED CHECKS: Any returned checks will be assessed a charge of $25.00.

CREDIT BALANCES: It is the policy of this office to refund any balance $5.00 and over. If you have a credit balance that is less than $5.00 and you request a refund, we will gladly refund the amount back to you if you call and notify us.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. We are here to serve you.

I have read the Financial Policy. I understand and agree to this Financial Policy.

X_____ Date: _____

Signature of Patient or Responsible Party

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Please PRINT Name