# Financial Policy

**If you have a medical insurance or Vision Service Plan (VSP), we are committed to helping you receive your maximum allowable benefits. In order to achieve this goal, we need your assistance and understanding of our financial policy.**

- As a courtesy to our patients, our office will file with your insurance. However, you are responsible for any unmet deductible, coinsurance or copays and any non-covered services. In order for us to file your claim in a timely manner a copy of your Medicare and/or insurance card will be needed as well as your referral from your primary care physician, if required by your insurance carrier.
- It is your responsibility to know your insurance coverage and to provide our office with the most current and accurate information. While our staff is extremely knowledgeable about many insurance plans, we are not aware of every plan and their specific details since they constantly change. We are not liable for misquoted benefits or eligibility.
- The determination of your best corrected vision is called a refraction. This is considered a non-covered service/procedure by most ***medical*** insurance companies. If this service is not covered, you will be responsible this service fee of $85.
- If your insurance requires a referral, you are responsible for contacting your primary care physician/pediatrician to obtain said referral prior to beginning your appointment. If a referral is not obtained, you will be responsible for the services. It is also your responsibility to verify that valid referrals are on file for any follow up care.
- If purchasing contact lenses with our office, you are responsible for paying fees at the time of visit and/or ordering.
- You have acknowledged that you have provided Dr. Goodman's office with all your current insurance information for billing purposes. **PLEASE INITIAL HERE __________**

**I understand that even if Dr. Goodman is contracted with my health care plan, I am responsible for payment of both covered and non-covered services performed during the course of my treatment. I authorize release of medical information to the insurance carrier or its agents to allow for benefit or claim determination.**

Signature of Responsible Party: ________________________________ Date: ___________

Print Name: ___________________________________