VIRGINIA FAMILY
EYE CARE

# Financial Policy

## PAYMENT RESPONSIBILITY

Payment for services is due at the time services are provided unless prior arrangements have been made.

The patient or responsible party is financially responsible for all charges incurred, including deductibles, co-payments, co-insurance, non-covered services, and any balances not paid by insurance.

## INSURANCE

As a courtesy, Virginia Family Eye Care will submit insurance claims on your behalf when possible.

Please understand:

Insurance verification is not a guarantee of payment

Coverage is determined by your insurance plan, not by our office

Any unpaid balance after insurance processing is the responsibility of the patient or responsible party

If insurance information is not provided or is invalid, the full balance will be the patient's responsibility.

## NON-COVERED SERVICES

Certain services, products, or materials may not be covered by insurance, including but not limited to:

Refraction or vision exams

Specialty testing

Contact lens evaluations

Eyewear materials or upgrades

You will be informed of non-covered services when possible, and payment will be required at the time of service.

## MISSED APPOINTMENTS / LATE CANCELLATIONS

Missed appointments or appointments canceled without adequate notice may result in a $35 missed appointment or late cancellation fee.

Repeated missed appointments may result in dismissal from the practice.

## REFUNDS

Refunds for overpayments will be issued when applicable. Fees for services already rendered are non-refundable.

There are no refunds for eyewear or contact lens purchases.

## COLLECTIONS

Unpaid balances may be sent to a collection agency if not resolved in a timely manner. The patient or responsible party may be responsible for any costs associated with collections as permitted by law.

## MINORS

For patients under 18 years of age, the parent or legal guardian accompanying the minor is responsible for payment at the time of service unless other arrangements have been made in advance.

## ACKNOWLEDGMENT & SIGNATURE

By signing below, I acknowledge that I have read and understand the Financial Policy of Virginia Family Eye Care. I agree to be financially responsible for charges incurred and certify that I am the patient or the legal parent/guardian authorized to sign on the patient's behalf.

Patient / Guardian Name: _____

Signature: _____

Date: _____