# GLENDA B. SECOR, O.D., F.A.A.O., INC
# MARY A. COTE, M.D.

## Patient Financial Responsibilities

First, we would like to welcome you to our office. To make your visit simplified, we ask that you come to your appointment prepared with the following information regarding your financial responsibilities.

***Eye Care Services:*** Our office provides a full scope of eye care services including routine **vision care** (i.e.: check-ups, glasses, and contact lenses), as well as **medical care**, such as treatment for eye infections, dry eye and lid disease, ocular allergy treatment, cataracts, glaucoma and trauma related care.

**PPO'S-** We can bill your medical insurance, but we cannot guarantee any or all coverage. What your insurance company "deems" medically necessarily has no bearing on the quality of care we provide. Most medical plans do not cover refractions- (this is your glasses prescription) or your contact lens exam. Please let your Doctor know **ahead of visit** if you do not want either service. Be prepared to pay your co-pay and services not covered by insurance on your visit. Please present all insurance information upon arrival.

**HMO'S- We are not contracted with any HMO insurances.** If you are insured by an HMO plan, you may elect to have services in our facility, but note this will be on a cash basis only. If you are paying out-of-pocket, we do offer discounts on services but only if paid on the same day.

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Please Initial

Payments for services rendered or not covered by insurance is your responsibility. A missed appointment cancellation fee is $50.00 and may incur without 24-hour notice. Returned checks due to nonsufficient funds will incur a fee. If your account is turned over to a collection agency for non-payment, there could be additional agency fee incurred.

All glasses orders are subject to a cancellation fee after 24 hours. Please understand that your lenses are custom ordered for you! When your eyeglass order arrives in our office, you have a 90-day period to return your eyeglasses with a 20% service fee. This is the total lens charge (including any extra options). After the 90-day period, there is no return credit. Thank you!

I have read this Patient Financial Responsibilities and I am aware of its requirements.

Patient or guardian
print name:_____

Patient or guardian
signature:_____ Date:_____

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