NORTON EYE CARE

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Financial Responsibility Statement & Acknowledgement of Office Policies, Consent to Treat

Insurance Information

It is your responsibility to know the terms and limitations of your policies. Failure to inform us of all your insurance information may result in a denial of benefits and payment in full being owed by you. Your insurance company is required to respond to our claim submission within 30 days. If we receive no response from your insurance company, we may ask you to contact your insurance company or remit payment yourself and seek reimbursement from your insurance company. Medical insurance and vision plans are very different in terms of service and coverage. We are unable to determine which, if any, can be billed until after the examination is completed. When a medical condition is present (diabetes, hypertension, dry eyes, red eyes, allergies, etc.) it may be necessary to file the claim with your major medical carrier. Vision plans do not cover medical problems, just as medical plans do not cover routine glasses and contact lens exams. We are unable to bill your vision plan for the glasses/contact lens portion of your exam on the same day we bill your medical insurance for management of your medical eye problem. Our office does not make these billing rules; they are defined by the insurance carrier.

Financial Policy

Payment is expected at the time service is rendered and before orders are placed. By signing, you agree to be held liable for all expenses, costs, and reasonable court, attorney, and collection agency fees for any delinquent balance. A collection service fee will be assessed for any unpaid balances after 30 days of initial notice of balance due. Our office may assess an administrative fee for completion of any outside paperwork, forms, and charts reviews requested by you.

Appointment Cancellations

We make every effort to confirm appointments 24 to 48 hours before your arrival. Appointment cancellations with less than a 24-hour notice or no shows will be assessed a $35 fee. In consideration of other patients, please make every effort to arrive on time. If you are more than 10 minutes late, we may need to reschedule your appointment.

Vision/Medical Benefits

It is your responsibility to know your coverage and co-pay amounts. Please be aware, unless your insurance plan has specific benefits for contact lens evaluations, you will be expected to pay the contact lens evaluation fee along with your comprehensive exam co-pay and any other non-covered services.

Any out-of-pocket expenses collected from you at the time of service are estimates only. Your insurance will determine your final out of pocket costs. In the event that your insurance carrier determines that you are not eligible at the time of service, or makes a determination that you are eligible for a reduced level of coverage, by signing this statement, you hereby agree to be financially responsible for any and all charges incurred by you and not paid by the insurance carrier, and any additional collection fees necessary to collect all amounts due. Be aware that any pre-authorizations received by our office are not in any way a guarantee of payment from your insurance carrier. By using your vision/medical insurance, you authorize them to pay Norton Eye Care the benefits otherwise payable to you, the patient, and that the insurance carrier may pay less than the accrual bill for services. After we receive your insurance carrier's response, any and all remaining balances will be due within 30 days. If we do not receive a response from your insurance company within 90 days, we will bill you for the balance due in full. Due to the time limit restrictions imposed by many insurance companies, failure to supply us with the correct insurance information may result in payment in full being owed by you.

Norton Eye Care Satisfaction Policy

In the event that you have difficulty seeing out of your new eyeglass lenses, this office will perform a refraction one time after the initial exam at no cost within 60 days of the date on which the prescription was determined. If you have unresolved medical conditions, this policy does not apply, and you may be charged a fee. You must be able to furnish the glasses/contacts that you had filled with the aforementioned prescription if not filled through our office. A fee to confirm the parameters of a prescription pair of glasses not purchased in our office or online store may apply. Other restrictions apply, ask an associate for details. After 60 days, a fee will be incurred for any recheck. Rechecks will not be performed 6 months after the original exam date and a new exam will be necessary.

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Norton Eye Care Remake Policy and Frame and Lens Warranty

This office will remake prescription glasses once within 60 days of order at no charge to the patient in cases of prescription change. Any changes required beyond the initial remake or due to patient desiring a restyle will result in fees for the lenses and any treatment charged at 30% off our usual and customary fees. There will be a $25 restocking fee for all returned frames. Any frames or spectacle lens restyle must be redone within the first 20 days of purchase.

Warranties do not cover loss or theft. If you used vision insurance to purchase your glasses, your warranty changes from our standard office warranty to your insurance company's warranty.

Pupillary Distance and Other Eyeglass Measurements

This office takes pupillary distance and other measurements to properly fit prescription glasses as part of the service provided for your eyewear purchase form our office. Patients that do not purchase prescription eyewear through our office will be charged a fee for taking measurements in conjunction with our prescription verification service.

Refund Policy

All orders are final when placed. No refunds are given on custom-made prescription items. If you are unhappy with your glasses for any reason, please bring them back to us so we may change them to meet your expectations. Any contact lenses purchased from our office may be returned less a restocking fee. Opened or damaged boxes cannot be returned. Refunds will not be given on services provided. New contact lens wearers that opt not to complete training and fit will be charged 50% of the fee. If you return within 6 months to try again, you will only be charged the additional 50% of the fee.

Privacy Policy, HIPPA and Your Records

This office follows HIPPA guidelines concerning the privacy of your medical information. We will not release any of your information to anyone without your written prior authorization with the exception of other health professionals and your insurance company as outlined in HIPPA, if applicable. I authorize the release of any medical records to my insurance carrier that is 1.) acquired during my exam and/or treatment, and 2.) any information which may have any bearing on the benefits payable under my plan. A copy of the HIPPA guidelines is available upon request. Under Michigan law, your records will be maintained for a minimum of 7 years. You do agree to allow us to contact you at any phone, wireless number, text, or email address provided by you, which may result in charges to you.

Consent for Treatment

I hereby authorize Norton Eye Care, PLLC and/or such assistants as may be requested by said physician to perform the above noted medical treatment as explained to me. I hereby acknowledge and agree that if my insurance does not cover the treatment authorized above, I will be personally responsible for paying the financial charges for those services.

I understand that this medical treatment is not without risks. The benefits and risks have been explained to me.

Potential risks associated with the medical treatment include but are not limited to the risk of infection on the site of incision, bleeding that may require a secondary procedure, scar tissue formation and discomfort or pain at site.

I accept the treatment recommendation of my physician. I acknowledge that no warranty or guarantee has been made as to the results of this treatment. I understand that any aspect of this consent form that I do not understand can and will be explained to me in further detail by asking my physician. I further certify that my physician has informed me of the nature and character of the proposed treatment, of the anticipated results of this treatment, of the possible alternative treatments choices, and the possible risks, complications, and anticipated benefits involved in the proposed treatment, including non-treatment.

The procedure as stated, including the possible risks, complications, options, and expectations have been explained to me or my representative and consent is thus given as noted by signature.