Notice of Payment Policies & Procedures

PAYMENT POLICY: It is customary to pay for professional services when rendered. For your convenience we accept MasterCard, Visa, Discover, American Express, checks or cash.

INSURANCE BENEFITS: You agree that we will request payment of authorized insurance benefits to be made for charges on your behalf to STL VISION for any unpaid medical / surgical procedures performed now or in the future. We must obtain a copy of identification and proof of valid insurance. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for the balance of a claim. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. You must notify us of any insurance changes prior to services being rendered.

COPAYMENTS & DEDUCTIBLES: All copayments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Please help us in upholding the law by paying your co-payment at each visit. Deductibles and coinsurance will be collected prior to any surgical procedures. Adult patients are responsible for their bill at the time of service. The responsibility for minors rests with the accompanying adult.

NON-COVERED SERVICES: The filing of a claim for any service rendered DOES NOT GUARANTEE PAYMENT from your insurance company. Some - and perhaps all – of the services you receive may be non covered or not considered reasonable or necessary by insurers. You will be financially responsible for these services. You are responsible for any balances after your insurance(s) has cleared.

SELF PAY: Self pay fees for services will be provided to you in writing prior to services being rendered. Payment in full will be collected prior to any examination or procedure.

NONPAYMENT: If your account is 90 days past due we may refer your account to a collection agency.

REFRACTION POLICY & DILATION POLICY: During your visit, a refraction may be performed to determine your need for glasses or to evaluate if any further visual improvement can be achieved. This is a necessary and essential portion of your eye exam and in some cases it is the sole reason for the appointment. However, the refraction is considered a NONCOVERED service by some insurance companies. Please be aware it is the responsibility of the patient to pay for the refraction. Our office currently charges $80.00 for this procedure, but provides a prompt pay price of $35.00 to the patient when paid at the time of service. The refraction fee is in addition to the fee for the eye exam and is in addition to the patient's copay.

CONTACT LENS POLICY: The glasses prescription you receive from STL VISION is NOT a contact lens prescription. There is a separate fee for a contact lens fitting, which varies greatly depending on the type of contact lenses that are right for you, if you have been fitted before, and other individual factors. After your contact lens fitting is completed and services incurred are paid for, you will receive a copy of your contact lens prescription.

EYE EXAM: You agree to and understand that eye(s) must be dilated in order for the doctor to thoroughly examine your eye(s). If your pupils are dilated or an eye is patched after the exam, you may not be able to safely operate a motor vehicle. The decision to operate a motor vehicle after dilation is solely the patient’s therefore, STL VISION will not be held responsible.

OPTICAL POLICY: Glasses are a custom made product for your visual needs. A minimum of 50% payment is expected prior to an order being placed. Payment in full will be collected prior to any item being dispensed. We are a small family run practice, therefore all canceled or returned orders will incur a 50% restocking fee as we receive no credit from manufacturers on materials already purchased.

The contents of this document remain in effect unless revoked by either party in writing.

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Signature of Patient or Representative Date

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Printed Name/Relationship to Patient

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Signature of Witness Datee