Vision Source Herndon - Dr. Finley's Family Eyecare, Optometrists
709 Pine Street
Herndon, Virginia 20170

# OFFICE FINANCIAL RESPONSIBILITY

Welcome to our office. To help better serve you, please read and sign the following financial responsibility:

1. Payment in full is due at the time of service and order unless an arrangement is made beforehand. We accept cash, check, Visa, Master Card, American Express, and Discover. We also offer Care Credit.
2. All checks returned by the bank for insufficient funds will incur a $30.00 bank and administrative fee. We will notify you about your returned check and your new $30.00 fee so you can send in your payment.
3. Your appointment time is reserved exclusively for you. We require 24-hour notice for all cancellations. There is a $50.00 charge for a missed appointment without 24-hour notice.
4. Balances 30 days past due are subject to a $10.00 monthly rebilling fee. If this account is turned over to our attorney or collection agency, you agree to pay all fees including court costs and added interest from the initial statement date.
5. A 50% deposit is required on all materials ordered and the remaining balance is due when the materials are dispensed.
6. Patients who need insurance referrals are responsible for arriving with them or will be responsible for paying for services in full.
7. All patients wearing contact lenses receive tests and follow-up care above and beyond a comprehensive exam. This is referred to as a "Contact Lens Medical Evaluation" and is performed on all patients wearing contact lenses every 12 months whether or not new contact lenses are purchased. There is an additional charge for this service. Most Insurance plans do not cover contact lens related charges. If you do not wish to incur any contact lens charges, please inform our staff and remove your contact lenses before your examination begins. However, we will not be able to dispense any more contact lenses, write a prescription for contact lenses, or be responsible for your contact lens exam.
8. As your provider, it is our responsibility to provide you and your family with the best possible care. Please remember, your insurance policy is between you and your insurance company, and not between your insurance company and us. For our insurance patients:

• Please be aware that each insurance company has dozens of plans, all a little different. It is impossible for our staff to have complete knowledge of each one. We will do our best to quote your portion of the bill when you are here, but as your insurance company tells us, they will not guarantee paying their quoted amount until they personally process your claim. In the event that we receive more payment than expected, you will be refunded. However, if there remains a balance due, you are responsible for all charges. Also, if your insurance company has not paid your bill within 30 days, the responsibility for payment will be returned to you.

If there are any questions concerning your bill, please ask us. Your signature indicates that you have read, understand, and agree to all of the above policies. As a responsible party, your signature indicates acceptance of the above policies and authorizations.

Signature_____Date_____

Printed Name_____

Patient Name_____

Relationship to Patient_____