



HELLERSTEIN & BRENNER
VISION CENTER, P.C.

LYNN F. HELLERSTEIN, O.D., F.C.O.V.D., F.A.A.O. • TRICIA BRENNER, O.D. • SARA K. GRELL, O.D. • AMY E. ELSILA, O.D. • ALEXANDRIA R. WISS, O.D.

FINANCIAL POLICY: HELLERSTEIN & BRENNER VISION CENTER, P.C.

We are pleased you have chosen us to provide your care. For your convenience, we are providing you with an explanation of our payment policies.

We accept **cash, personal checks, Visa, MasterCard, and Care Credit** for payment on your account. **Full payment is due at the time of service.** A minimum fee of \$20.00 will be charged to your account for returned checks.

USUAL and CUSTOMARY FEES: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area, not necessarily what is customary to your insurance carrier.

NON-PAYMENT: In the event your account becomes delinquent, you will be responsible not only for charges incurred, but also for costs involved in the collection of fees, court costs, and attorney fees. Insurance coverage is a matter between you and your insurance company. You are ultimately responsible for the payment of your account.

LATE CHARGES ON BALANCE OVER 30 DAYS: Accounts are subject to a late payment charge of 1.65% per month (19.8% per year), if not paid within 25 days of statement date.

If insurance is applicable: **VISION insurance carrier:** _____
Subscriber ID# (VSP is SS#): _____
Primary member name: _____

MEDICAL insurance carrier: _____
Subscriber ID#: _____
Primary member name: _____

I authorize my insurance company to send payment directly to Hellerstein & Brenner Vision Center

Signature Date: _____

I have read and understand this financial policy:

Signature Date: _____

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PRIVATE INSURANCE: If you have insurance that we do not contract with, you will be expected to pay for your visit in full at the time of service. It is your responsibility to submit for reimbursement of services.

MEDICARE: We are a participating Medicare provider. We will submit your insurance form to Medicare. Medicare will then process the charges and send payment directly to us. You will be responsible for deductibles, co-payments, and charges Medicare does not allow.

CONTRACTED INSURANCE: If our doctors are on your insurance panel, we will submit your insurance claims if you supply us with the necessary information: a copy of your card, an address to submit claims, and a telephone number allowing us to verify your coverage. You are still responsible for payment of your co-pay at the time of service, and any amount not covered by your insurance including deductibles. If additional testing/therapy is recommended, pre-approval from your insurance company is necessary. If coverage is denied for any reason, you are responsible for payment of the entire balance due based on our usual and customary fees.

AUTO INSURANCE: If your visit involves an accident related injury, you are responsible for payment at the time of your visit unless prior approval has been given to us in writing by your insurance company. As a patient, you are ultimately responsible for payment of services rendered.

INSURANCE REPORTS/COPIES: If your insurance company requests a report regarding your treatment, it will be sent directly to the insurance company and we will bill them \$15-\$75, based on the type of report requested. Should the insurance company not pay for the report, you will be responsible to pay the amount not covered. Charges for photo copies will also be charged to your account.

