VISION CLINIC
Dr. Savin and Associates
1421 Washington Ave. Racine, WI 53403 • 637-7494

Financial Policy (Revised 11/01/2013)

This is an agreement between you and Vision Clinic Dr. Savin and Associates. By signing this agreement you are acknowledging the policies and procedures in accordance to all financial policies. You have agreed to the terms below.

1. **Payments**
    a. 100% down is due for any ordering of materials.
    b. If you do not pick up your materials within 60 days of notification you will forfeit the cost of materials ordered.
    c. Returning or cancelling of any orders: There will be a 25% restocking fee (this is non-negotiable as we will still be required to pay for the items.
    d. All co-pays and deductibles are due at time of services rendered.
2. **Returned checks**: There is a fee of $25 for any returned or NSF checks. If a check is returned you will be required to pay by cash or credit card from that day forward.
3. **Past due accounts**: If your account becomes past due (over 90 days) and we require legal action to collect the balance you will be charged all filing and court costs incurred by Vision Clinic.
4. **Waiver of Confidentiality**: You understand that if legal action is required your financial and personal information will be given to the correct agency in order for them to begin collection process.
5. **Insurances**:
    a. You understand that it is your responsibility to update all insurance information on every visit. This includes Vision, Medical and secondary insurances. If you do not do so you agree to pay all fees for that visit and self submit on your own behalf.
    b. You understand that if insurance determines services were not medically necessary that these fees will be your responsibility. By having the services done you have agreed to take full responsibility for the incurred charges.
    c. You understand that co-pays, coinsurance and deductibles are non- negotiable because they are determined by your insurance. To eliminate those charges violates state and federal laws. You are responsible for these fees regardless of whether Vision Clinic gave you prior knowledge or not of that amount.

This form is effective for three years from the date signed and unless policies are changed.

Patient Name _____

Responsible Party for all financial _____

Date _____