



Financial Agreement & Privacy Information

At Harrisburg Eye Care, we want to keep our fees as affordable as possible. In an effort to do this, we have instituted the following financial policies.

Payment is due in full at the time services are rendered. We prefer full payment for glasses at the time of order, but we will accept a deposit of 50% with the remaining balance due when the glasses are dispensed. Contact lens purchases must be paid in full before we will make the order.

You are responsible for any balance not covered by your insurance. Payment is expected in full within 30 days. After 30 days, a 1.5%/month finance charge will be assessed. If you cannot pay due to financial hardship, please let us know and we will do our best to assist you.

Understanding Vision Plans and Medical Insurance

Vision plans only cover "routine" exams and a portion of your glasses and contacts purchase. Routine exams include yearly checkups and exams for blurry vision due to a prescription change.

Any exams for a medical complaint (diabetes, headaches, dry eyes, red eyes, cataracts, glaucoma, etc) must be billed to your medical insurance. Vision plans do not cover exams for medical complaints.

Applicable copays, deductibles and coinsurance will apply.

I have read and understood the above information and agree to comply with these terms. I authorize and request my insurance company to pay directly to Harrisburg Eye Care, PC, insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of me or my dependents. I authorize the professionals of Harrisburg Eye Care, PC, to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such eye care to third party payers and/or health practitioners. I understand that I have been given the opportunity to review the Notice of Privacy Practices for Harrisburg Eye Care, PC, and understand that I may request a copy of this notice should I so choose.

Patient or Representative Signature _____ Date _____