PROCEDURES FOR FILING INSURANCE, CONTACTS, & ORDERING GLASSES

- It is the policy of Vision Source/ Professional Eye Care of Statesboro to file the insurance presented the day of service. **If some fees are not paid by your insurance, we will bill you for them, such as deductibles, co-pays or non-covered services as allowed by the insurance contract.** Please be aware the insurance information you give us is what will be filed the day of your visit. **If the information is not correct, patient will be responsible for paying their balance and refiling their insurance with an itemized statement that is requested from the patient.** It is the patient's responsibility to make sure that we have the correct insurance on file. Please keep us updated and current on any changes in your insurance. **Our office files your insurance as a courtesy to you. If for some reason your insurance does not respond to the filed claims, you will be responsible for the balance that the insurance did not pay.**

- For patients who have **VSP INSURANCE- WE ARE OUT-OF-NETWORK.** It is your responsibility to know if you have out-of-network benefits. If you do not have out-of-network benefits you will be responsible for your visit.

- For patients trialing or ordering contact lenses, please be aware you are responsible for paying a **contact lens evaluation fee at least once a year to update your contact lens RX**. **The fee must be paid in full at the time of visit or trials will not be issued and contacts will not be ordered.**

- For patients purchasing glasses (frames or lenses), please be aware no matter if filing through insurance or paying out of pocket, **there will be no refunds on glasses once the patient leaves the building and glasses are ordered. It is considered a final sale once glasses are paid for.**

- For patients who have **UNITED HEALTHCARE** insurance for materials, please be aware that **most United Healthcare materials are now SPECTERA. Our office does not accept Spectera therefore you may be responsible for your materials.**

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Patient Signature (Parent if child) Witness

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Patient Name (Print) Date