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Colleen Govekar, O.D.

### Financial Policy

The following is a statement of our financial policy. ***Please read carefully*** and sign at the bottom.

**Routine Exam:** We will bill your insurance provided you have routine coverage and are eligible at the time of service. We must have a copy of your insurance card to bill your insurance (except VSP, VBA, VCPA). If you cannot provide this card, you must pay for your visit in full at the time of service. If prior authorization or unique claim forms are required, it is your responsibility to obtain this prior to your visit. All co-pays are due at the time of service. ***It is your responsibility to know the benefits and coverage requirements of your insurance policy.***

**Medical Exams:** We must have a copy of your insurance card to bill your insurance. If you cannot provide your card, you must pay for your visit in full at the time of service. If your insurance requires a referral, it is your responsibility to obtain this prior to your visit. If you do not obtain the referral, you will be responsible for all charges. If you require assistance in this, our office may be able to help you.  
***It is your responsibility to know the benefits and coverage requirements of your insurance policy.***

**Optical Orders:** We will bill your insurance provided you have optical benefits and are eligible at the time of service. We must have a copy of your insurance card to bill your insurance (except VSP, VBA, VCPA). If you cannot provide a card, you must pay for your order in full at the time of service. If prior authorization or unique claim forms are required, it is your responsibility to obtain this prior to your visit. ***It is your responsibility to know the benefits and coverage requirements of your insurance policy.*** Our policy is to collect at least one half of the balance due for optical orders. The remainder is due upon receipt of your order as an order **cannot** be released until it is paid in full.

**Contact Lenses:** Please note that additional services are required that would not be necessary for a normal vision exam. A contact lens exam fee is charged in addition to the normal vision exam fee. *Most insurance companies will not cover this fee.* This fee includes three months of follow up care with our doctors and is due at the time of service. When possible this fee will be charged to your insurance, but must be charged with a contact lens order. ***It is your responsibility to know the benefits and coverage requirements of your insurance policy.***

**Return Policy:** When materials are ordered from our office, payment is expected in full at the time of the order. You have 60 days from the date of dispense to cancel or return the product and receive a refund or in store credit. After 60 days all sales are considered final and no refund will be given. Our office charges a 20% restocking fee for any returned glasses or unopened contact lenses.

**All co-pays and other balances are due at the time of service. A \$10.00 fee will be assessed if co-pay is not paid at the time of service. After your insurance company has processed the claim, if there is any balance due from you, such as a deductible or co-insurance, we will send a statement to you. Balance is due upon receipt of the statement. If payment arrangements are not made, you may be sent to collections, after which we no longer have control of the account and can no longer discuss details of your account with you.**

We will do our best to verify your insurance eligibility and benefits at the time of service. However, a quotation of eligibility and benefits from your insurance company does not guarantee payment. ***Please understand that financial responsibility of your account is yours, not your insurance company's.***

An NSF fee of \$20.00 will be assessed for any check returned by the bank.

For your convenience, we accept cash, check, Visa, MasterCard, American Express, Discover and Flex spending cards. If you are uninsured, full payment is due at the time of service.

I have read, understand and agree to this financial policy.

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Signature of Patient/Guardian

Printed Patient Name

Date

Ponderosa Vision Clinic, PC  
14991 E Hampden Ave. #110  
Aurora, CO 80014  
303-693-9561  
303-693-0713 fax

Lowry Eye Care Specialists  
8101 E Lowry Blvd. #110  
Denver, Co 80230  
303-671-0000  
303-671-2879 fax

Associated Eye Care Services, LLC  
8101 E Lowry Blvd. #110  
Denver, Co 80230  
303-671-0000  
303-671-2879 fax