FAMILY EYE CARE
14855 Blanco Road, Suite 210 | San Antonio, Texas 78216
210-479-0900 main | 210-479-0903 fax | www.safamilyeyecare.com
contactus@safamilyeyecare.com

Financial Policy

Payment Options

Cash, Visa, MasterCard, CareCredit or Discover Card

Minors Accompanied By an Adult

The adult (parents and/or guardian) accompanying a minor is responsible for payment upon completion of the exam or consultation.

Notice

It is customary to pay for professional services when rendered, even if no medical eye problem is known or suspected by yourself or by our staff. Once your vision care has begun, changes in the anticipated vision care plan may be required. This may occur when the Doctor determines that your routine refraction or routine eye exam reveals a medical problem; if that happens, we will bill your medical insurance on your behalf, and charge your medical copays. We will inform you if this occurs and you will be given the option of continuing or changing your vision care.

A refraction is a measurement of the lens power necessary to prescribe glasses or other corrective lenses. Most medical insurance plans, including Medicare, do not cover routine eye exams (when no medical eye problem is known or suspected). Medicare, and most other insurance plans, insists that we charge separately for that portion of the examination, since it is not a covered service. You will receive an explanation of benefits from them itemizing your financial responsibilities. You will be responsible for any co-payments, deductibles, or non-covered services as determined by your insurance company.

We are a Medicare participating practice. If you are a Medicare Beneficiary, we will file a claim for you. You will be responsible for the annual deductible and the 20% co-payment after deductible and refraction (glasses prescription).

If you have a separate plan that covers routine or annual eye examinations and/or glasses, please let us know. Your vision plan may assist you with your eye care needs that are not covered by your medical plan. We will bill your medical and/or vision plan as above.

Your insurance is a contract between you, and/or your employer, and the insurance company. We are not a party in that contract. Therefore, we will not become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance, and “usual and customary” charges. Therefore, we are only responsible for collecting, and you are responsible for paying, co-payments, etc.

Family Eye Care requires payment at the time of exam or consult. Family Eye Care requires a 100% payment at the time of purchase or (if shipping is required) prior to shipment.

Family Eye Care will make every attempt to verify your insurance eligibility prior to your appointment. If the information we have on file is incorrect, we will contact you. Delay in providing us your information may result in rescheduling of appointment.

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The following fee schedule will apply to the Non-Insurance covered, Non-Family Eye Care materials, and frames, and Non-Medicare covered services. Family Eye Care requires a fee for the following:

Eye exam (Out of Pocket) $65+
Refraction fee (Out of Pocket) $35+
Contact lens exam (Out of Pocket) $110+
PD Measurement (If glasses are not purchased from us) $10+
*Adjustment(s) and/or Repair(s) fee $10+
Warranty fee $10+
Miscellaneous (Records request, etc.) $10+
Lens Pair Warranty Shipping and Handling $5+
*Frame Breakage Warranty Shipping and Handling $20+
Approved Contact Lens Returns $3 per box Plus $20+ Shipping and Handling
*Frames and/or any adjustments carry no actual or implied warranty

Disclaimer of Consequential Damages:

Except for willful misconduct, Family Eye Care will not be liable to you (the customer) for indirect, incidental, consequential, exemplary or punitive or special damages of any kind arising out of or in connection with Family Eye Care services and/or products, including, but not limited to, lost profits, however caused and on any theory of liability (whether in contract, tort (including negligence), strict liability or otherwise), even if such party was advised or otherwise aware of the likelihood of such damages and regardless of any notice of the possibility of such damages; provided, however, that the foregoing disclaimer does not apply to or limit either party's indemnification obligations with regard to third person claims.

Billing, Past Due Fees and/or Interest, Missed and/or Cancelled Appointments

We charge an annual rate of 18% interest on all past due accounts.

A fee of $50 is charged for patients who missed 1 appointments and/or cancelled 2 or more appointments in a calendar year without a 24-hour notice. Patient must assert any claim or dispute arising from charges billed on the account within 30 days from invoice and/or notification date. Should it become necessary to place the account with a collection agency or attorney, the patient agrees to pay all collection costs and attorney fees in addition to all other sums due.

I hereby assign, transfer, and send over to Family Eye Care all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until I revoking said authorization give written notice. I understand that I am financially responsible for all charges whether they are covered by insurance.

Fees for all services, including unpaid balances, deductibles, coinsurances, and co-payments, are due at the time of service. Returned checks are subject to a return check fee.

Lastly, if we do not receive payment from your insurance carrier within 30 days from date of service, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.