Vision Plus Crossroads
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support@visionpluscrossroads.com

Financial Policy

Our credit and collection policy is in place to retain financial resources and maintain excellent care for our patients and community.

Vision Plus Crossroads will bill your insurance, however, it is your responsibility to verify your benefits and ensure your visits will be covered under your policy and that any referral or authorization is in place before you are seen. Services not covered by your policy could be subject to out of network benefits resulting in higher patient responsibility. You will need to provide all information necessary for Vision Plus Crossroads to bill your insurance provider. This includes: **Subscriber's name, date of birth, social security number, complete name and billing address of your insurance company, and the ID and group numbers of your policy.** Copays are due at the time of service. This is a requirement by the contract you have with your insurance company. Deductible or balances owed are due within 30 days of the statement you receive. NSF checks will be subject to a $40 processing fee that will be added to your statement balance.

In the event of an insurance claim rejection or denial, the patient is responsible for payment for all services provided. Third party claims, no insurance coverage and those involving attorneys negotiating settlements will be expected to pay at the time of service. Vision Plus Crossroads will only mail statements to the guarantor address.

Notice of Privacy Practices – Acknowledgement

We keep a record of the health care services we provide you. We will not disclose your record to others without your signed consent or the law authorizes us to do so. You may ask to see, copy, or correct your records.

By my signature below, I acknowledge that I have read and understand the above Financial Policy and Notice of Privacy Practices. I also understand that I may call the office and request more information about my records at any time.

_____ _____

Patient or legally authorized individual signature | Date

_____ _____

Printed name if signed on behalf of the patient. | Date

*This form will be retained in your medical record.