Washington Eye Specialists
"Excellence in Eye Care"
1160 Varnum Street, NE
Suite 011
Washington DC, 20017 202-529-5200

Financial Policy

Welcome to Washington Eye Specialists, we are pleased to have you as a patient and we are committed to providing you with the best care possible

Fee and Payment Policy: Deductible and copayments are due at the time of service. We will submit claim to your primary insurance and as a courtesy to your secondary insurance if necessary. We **will not submit claims to tertiary carrier**. You must present your current insurance card and picture ID at each visit and communicate changes in your personal information.
Medicare part B, Railroad Medicare, BCBS plans,Aetna, Cigna, Coventry, Tricare, NCAS, APWU,UHC and most commercial plans **will not cover refractions** (prescription for glasses). If you have this service, a fee of $60.00 will be collected at check out.

Patient Insurance: The patient is required to know if and when a referral is needed. Failure to provide the proper referral for the scheduled appointment will result in appointment cancellation.

Self pay: Patient without insurance or vision coverage will be expected to pay in full for all services rendered at the time of service.

Cancellation Policy: Should a patient need to cancel/reschedule an appointment, 48 hours notice is require to avoid the **no-show fee of $50.00**.

DMV form/Medical forms: $10 fee is charges for completion of the DMV form outside of an appointment. $10 fee is charged for completion of any Medical form.

Non-sufficient funds (NSF) Policy: a $50.00 fee will be added to any patient's balance if a check is returned to our bank for non-sufficient funds.
Collection process: Statements are sent monthly. If an account is over 60 days past due a collection letter will be sent. If the account is not paid within 10 business days from the collection letter, the account **will be forwarded** to our collection agency.

We do not accept Auto Accident cases or workman's comp. cases
I have read and understand the financial policy statement and agree to comply and accept responsibility for any payment that becomes dues as outlines in the financial policy.

Patient Signature: _____ Date :_____

Print Patient name : _____Date of Birth: _____

Thank you for choosing Washington Eye Specialists healthcare team, dedicated to excellence in patient care.