

N. SCOTT FERGUSON OPTOMETRIST

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PATIENT FINANCIAL POLICY

Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees or your financial responsibility.

If we are a provider for your insurance company, under applicable plans, we will gladly submit a claim for your visit. Submission of a claim DOES NOT guarantee payment from your insurance company. It is YOUR responsibility to contact your insurance company to see if your visit is a covered service.

INSURANCE VERIFICATION AND COPAYMENTS: Patients should expect to present an insurance card at each visit. Please be prepared to pay your co-pay and past due balances on the date of your visit.

SELF-PAY: If you do not have insurance coverage, payment in full is expected at the time of service.

PATIENT COLLECTION POLICY: Thirty days from the date of the first statement a patient's claim will be considered past due. If a patient is unable to pay their balance in full within thirty days, you will need to call our office to set up a payment plan.

REFERRALS: If your health insurance required a referral from your primary care physician it is YOUR responsibility to obtain it prior to your appointment. If you do not have your referral, you may be asked to re-schedule your appointment.

RETURNED CHECK FEE: Any returned check from the bank for non-payment (insufficient funds) shall result in the patient's account being assessed a \$25.00 fee per check returned.

I do not have a Vision Care Plan initial _____ Date _____

I have a Vision Plan, but will self-submit initial _____ Date _____

Medicaid is my secondary insurance, I realize I am responsible for any deductibles and copays.

Initial _____ Date _____

RESPONSIBLE PARTY SIGNATURE _____ DATE _____

WE ACCEPT CASH, CHECKS, MASTERCARD, VISA AND DISCOVER