

# SOUTHWEST VISION CENTER

## PAYMENT POLICY

Examination fee is due at the time of service. All eye wear (glasses and/or contacts) must be paid in full before ordered. Any co-payments are due at the time of service.

Returned NSF checks will be charged a service fee of \$32.47 (State of Texas allowable)

I HAVE READ AND AGREE TO THE PAYMENT POLICY STATED ABOVE.

\_\_\_\_\_  
Date

\_\_\_\_\_  
(Signature of Patient or responsible party)

## INSURANCE SUBMITTAL POLICY

If you have insurance coverage for these services or materials, we will submit claims for you, as a courtesy. However, we are not liable for collecting your claim. If your insurance has not paid in 60 days, you will be billed for all outstanding balances.

I HEREBY AUTHORIZE MY INSURANCE CARRIER TO MAKE PAYMENT DIRECTLY TO SOUTHWEST VISION CENTER FOR ANY AND ALL SERVICES RENDERED TO ME BY SOUTHWEST VISION CENTER. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES THAT ARE NOT COVERED BY INSURANCE.

I also release any information regarding my treatment or condition in order to obtain payment for the professional services.

I HAVE READ AND AGREE TO THE PAYMENT POLICY STATED ABOVE.

\_\_\_\_\_  
Date

\_\_\_\_\_  
(Signature of Patient or responsible party)