



405 S. 30th Street

Corner of 30th and Garfield

Laramie, WY 82070

**FINANCIAL POLICY**

*We hope you understand that our financial policies are established to assure the financial resources needed to maintain this office for all our patients.*

**PAYMENT**

Charges for services are due and payable at the time of service.. We accept cash, personal checks, Visa, MasterCard and Discover. Finance charges will be added to any unpaid balance over 60 days.

**HEALTH INSURANCE**

Your insurance policy is an agreement between you and your insurance company. Our relationship is with you and not with your insurance company. Therefore, all charges are ultimately your responsibility, regardless of your insurance status.

- ◆ If we participate with your insurance company, we will file the claim for you.
- ◆ If we do not participate with your insurance company, payment is expected at time of service.

Co-payments or other patient due amounts are expected at the time of service. Accounts 30 days past due are subject to collection proceedings unless prior payment arrangements have been made with our business office.

**LIFETIME INSURANCE AUTHORIZATION**

I authorize Snowy Range Vision Center to release to my insurance company any information needed to determine benefits payable for related services. I request that payment of Medicare, Medigap or other insurance benefits be made on my behalf to Snowy Range Vision Center for any services furnished to me by a Snowy Range Vision Center optometrist or supplier. I understand that I am responsible for all charges regardless of insurance coverage.

Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_\_

If you would like our office to leave messages or talk to any other person regarding your health or billing information please fill out the following information

\_\_\_ Snowy Range Vision can leave a message on my home phone      \_\_\_ Snowy Range Vision can leave a message on my work phone

\_\_\_ Snowy Range Vision can leave a message on my cell phone

\_\_\_ Snowy Range Vision can talk to the following people about my health information or billing

Name(s) \_\_\_\_\_

Relationship \_\_\_\_\_

Signature of Patient/Guardian \_\_\_\_\_ Date \_\_\_\_\_

**PLEASE RETURN THIS FORM TO A RECEPTIONIST.  
A COPY OF THIS FINANCIAL POLICY WILL BE PROVIDED IF DESIRED.**

<b>James A. Boucher, O.D., M.S., F.AAO</b> Professional Corporation Diplomate, Cornea & Contact Lenses	<b>Sue E. Lowe, O.D., FCOVD, F.AAO</b> Low Vision Vision Therapy	<b>Gary M. Poteet, M.S., O.D., F.AAO</b> Sports Vision Contact Lenses	<b>Michelle Chaney, O.D.</b> Contact Lenses Family Vision Care
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www.snowyrangevision.com