

Lisa K. DeMers, O.D.
Matthew C. Smith, O.D.
Courtney M. Smyser, O.D.
Jessica A. Kaminsky, O.D.



Hunter's Hill Eyecare Center

2811 N George St, Suite B
York, PA 17406
P: 717-848-2323
F: 717-846-0844
www.huntershilleyecare.com

Financial Policy:

Vision and Medical insurance are very different in terms of the services they cover, and it is important for our patients to understand those differences.

Vision insurance: Vision insurance is mainly designed to check the overall health of your eye and determine a glasses prescription. It is NOT equipped to deal with complex medical conditions and diagnoses.

Medical Insurance: Once a medical diagnosis is present (such as Diabetes, Macular degeneration, Cataracts, Thyroid eye disease, etc.), it is necessary to file your visit with your medical insurance. Treatment decisions are made by our doctors solely based on medical necessity, and the availability of insurance coverage is NOT a factor in this process. Insurance carriers set these rules, and our office is obligated to follow them.

Our office will submit all insurance claims, regardless of MEDICAL or VISION, on your behalf as long as we are a participating provider. As our patient, it is your responsibility to know whether your plan carries any deductibles or co-pays prior to your visits. Any co-pays listed will be required on the date of service. Glasses orders **REQUIRE** at least 50% of the total balance to be paid prior to submitting the order. You will then be responsible for the remaining balance at the time of pick up.

If your contact lenses are being shipped directly to you, they must be paid **IN FULL** prior to our office placing the order.

Please note that there are **NO REFUNDS** or **RETURNS** on glasses or contact lenses. **ALL SALES ARE FINAL.**

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Patient balances are expected to be paid within 45 days after being billed. Balances not paid within 180 days WILL be forwarded to our Collections Agency. If unpaid amounts are referred to a collection agency, you authorize that agency to contact you via phone, text or email. Communications may be sent using autodialers or prerecorded voice messages. Your consent is not a condition of receiving services. Standard message and data rates may apply. You may opt out at any time by contacting the collection agency directly. Effective March 25, 2024, our office will charge a fee of \$30.00 for any missed appointment or cancellation within 24 hours of the allotted appointment time. If your account becomes delinquent and sent to an outside collection agency, you will be responsible for the collection cost (35% of the balance due). There is a \$40.00 fee (per incident) for returned checks.

SIGNATURE ON FILE/ ASSIGNMENT OF BENEFITS: I authorize this form as a record of my signature for all of my insurance submissions. I request that payment be made on my behalf to Hunter's Hill Eyecare Center, LLC, for any services they have provided to me. Hunter's Hill Eyecare Center, LLC, accepts the Medicare charge determination as the full charge. **I AM RESPONSIBLE FOR ANY CO-PAYS, DEDUCTIBLES, CO-INSURANCE AND NON COVERED SERVICES.** My deductible and co-insurance are based upon the charge determination of Medicare and other insurance companies indicated by me. I understand my signature authorizes the release of medical information necessary at times for claims to be paid. I have read, understand, and agree to the financial policy.

Patient's Name/DOB (printed):

Patient's Signature/Today's Date:
