

Park Square Vision
31 St. James Avenue
Boston MA, 02116

Patient Financial Policy

In order to reduce confusion and misunderstanding between our patients and our office, we have adopted the following financial policy. If you have any questions about the policy, please discuss them with our front desk administrator. We are dedicated to providing the best possible care and service to you and regard your complete understanding of our financial policies and your financial responsibilities as an essential element of your care and treatment.

As a courtesy, we will file your insurance claim for you if you assign the benefits to our office; in other words you agree to have your insurance company pay our office directly. If your insurance company does not pay the practice within a reasonable length of time, we look to you for payment. (All claims are filed within standard HIPAA guidelines)

Your insurance policy is a contract between you and your insurance company. The office of Dr. Ira Bourne O.D. and Park Square Vision is not involved. If for any reason your insurance company does not pay our charges, you shall be ultimately responsible. Balances are due and payable in full at the time of billing.

Please note if there are any changes to your insurance, if the policy is terminated, your co-payment has changed, or you have new insurance coverage to notify us immediately.

Co-payments and deductibles are required at the time of service. We cannot bill your insurance company for these. We accept cash, check, MasterCard, Visa, Discover and American Express.

For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

In order to provide the best service and availability to our patients please call as early as possible if you know you will need to reschedule or cancel your appointment.

I have read and understand the financial policy of this practice and I agree to be bound to its terms. I also understand that such terms may be amended by the practice. In addition, I have received the HIPPA "Notice of Privacy Practice" policy.

Signature of Patient _____

Date _____