# Financial Policy
# H.M. Calvert MD & Associates

Patient Name:_____ Patient Date of Birth:_____ Date:_____

**VISION INSURANCE**
Name of Vision Insurance: _____ Member ID: _____

Sponsor Name: _____ Sponsor Date of Birth: _____

*FOR TRICARE ONLY*

*Sponsor Social Security Number: ____-____-_____ Patient Relation to Sponsor: _____

**MEDICAL INSURANCE**

***Primary***
Name of Medical Insurance: _____Member ID: _____

Primary Name: _____ Sponsor Date of Birth: _____

***Secondary***
Name of Medical Insurance: _____ Member ID: _____

Primary Name: _____ Sponsor Date of Birth: _____

Please initial next to each paragraph and sign on the back.

_____Payment is due at the time services are rendered. This includes copays, deductibles, and co-insurance. We will bill your insurance carrier; however, if they do not pay it is your responsibility to pay any remaining balances.

_____Insurance companies routinely indicate that coverage verification is not a guarantee of payment. Additionally, they indicate that not all services are covered under your particular insurance plan. While we do our very best to estimate your out-of-pocket expenses for your visit, the payment from the insurance company is occasionally less than expected after they process the claim. You are responsible for all non-covered charges.

_____If your insurance company pays LESS than the estimated amount, you will receive a bill from us. If your insurance company pays MORE than the estimated amount, we will apply the credit to future visits unless you indicate you prefer a refund.

_____It is your responsibility to give us complete and accurate insurance information and notify us if there are any changes. If we receive denials due to inaccurate information you will be responsible for the charges.

_____We do NOT participate in United Healthcare Dual Complete or HealthSpring.

_____If you have a health plan that requires an authorized referral (for example Tricare Prime), please make sure we have your referral on file before you see the doctor.

By signing below, I attest that I agree with the Financial Policy of H.M. Calvert MD & Associates.

_____ _____
Signature of Patient or Parent/Guardian Date

_____
Print Name of Patient

---

**FOR TRICARE PATIENTS ONLY**

**Tricare Active Duty** ONLY covers ONE exam per calendar year for dependents.

**Tricare Retired** ONLY covers One exam every TWO years from the last date of service. If it is after hours or a weekend and we can not reach Tricare to verify the last date of service, you will be responsible for payment at the end of the exam and we will reimburse you if we can verify your benefits.

**Tricare Select** is based on a deductible and also occasionally has a co-insurance that applies.

Diabetic Patients with Tricare Retired, your insurance covers one exam per year only if you receive a referral through Tricare from your primary care physician. Please ensure with the front desk staff that your referral has been received before seeing the doctor.

If you have **ANY OTHER HEALTH INSURANCE**, Tricare will not pay for your vision exam.

_____ _____
Signature of Patient or Parent/Guardian Date

---

**FOR VSP PATIENTS ONLY**

VSP will only cover contact lenses OR glasses lenses. Because we are out of network with VSP, our claims are addressed at a slower rate. This means that you may still show eligible with your insurance for a glasses or contact benefit after you've used it here until your insurance receives our claim. If VSP denies your claim due to you using befits elsewhere, you will be responsible for your charges.

_____ _____
Signature of Patient or Parent/Guardian Date