Payment Policy

Payment is due at time of Service. We accept cash, personal check, CareCredit, and credit cards.

All patients must pay co-pay or pay in full at the time of service. Fees will be calculated to the best of our ability with or without insurance but will be audited for accuracy by our billing department and/or thru your insurance company and additional charges may apply.

I understand that, although a New Concept Optical & Eyecare submits insurance claims to indicated carriers as a professional courtesy to facilitate such payments, it should not be considered a guarantee of resolution, and any balance left unpaid by my benefit carriers is my responsibility. I agree that in the event of non payment of any amounts due, I will pay interest thereon at the rate of 1.75% per month (21% per annum) and pay all reasonable attorney fees and court costs. I also agree that in the event this agreement is assigned to an agency for collection, I promise to pay an additional collection fee of 35% of the unpaid balance due.

Signature_____

Relationship to Patient _____

Date_____

I authorize the release of any information necessary to process my insurance claims and assign and request payment directly to Dr. Daniel Perala/A New Concept Optical & Eyecare.

Signature_____

Relationship to Patient_____ **Date**_____

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