HARBOR EYECARE CENTER

161 DEER STREET PORTSMOUTH, NH 03801
(P) 603-430-0211 (F) 866-694-2132

THIRD PARTY PAYMENT FOR SERVICES

Thank you for considering us at Harbor Eyecare Center for your visual needs! If you are requesting that we bill a third party on your behalf for the services we provide, such as Workers' Compensation, we allow up to $250 for any exams or office visits out to a third party insurance at any given time. Any balance that exceeds the $250 will be collected at the time of service, directly from you. Once we receive payment from the third party payer, we will reimburse you. If you prefer to submit for reimbursement from the third party insurance on your own behalf, then we will collect payment in full at the time of service

However, your personal medical insurance will be billed if the doctor deems your visit is NOT related to your injury

Please note- All glasses require payment in full before the Opticians will start your order. You have the option of paying in full at the time of service, allowing the Opticians to start your order immediately. This means that you will be able to pick your glasses up as soon as they are completed, rather than waiting for the third party to pay. You will then be reimbursed for the amount that the third party pays us. However, if you would prefer to wait and have us submit to the third party for hardware, we are more than happy to do so. Our Opticians will start your order as soon as we receive payment from the third party.

Any products must be paid in full at checkout. This includes items like vitamins, eye drops, any tools used for vision therapy training exercises, etc. Of course, we are more than happy to submit any products for reimbursement as well.

We want to exceed your expectations and meet your needs. Though we do everything we can to expedite the third party payment process, the payer does have up to 30 days to process claims. Please understand that there is never a guarantee of payment from third party payers. Patients are also encouraged to contact the third party payer to help expedite the process.

If you have any questions, please feel free to ask any of our staff members for assistance.

PLEASE SIGN BELOW TO ACKNOWLEDGE UNDERSTANDING OF ABOVE POLICY

Patient Printed Name: _____ Patient Date of Birth: _____

Patient or Representative Signature: _____ Date: _____

Representative Printed Name: _____Relationship to Patient: _____