

The Center for Eye Care and Optical
Patient Financial Responsibility Form

Patient Name: _____

Date: _____

Both the REFRACTION and the MEDICAL EYE EXAM are absolutely necessary to fully evaluate the health of your eyes and visual system. The only way we can sort out whether reduced vision is a matter of simple eyeglass adjustment or some other problem is to perform a REFRACTION.

Below are a list of some of the insurance companies that USUALLY cover the REFRACTION

MARCH VISION

SPECTERA

DAVIS VISION

NVA

UFT

VSP

UHC COMMUNITY PLAN

MEDICAID

SUPERIOR VISION

SOME EYEMED PLANS

SOME BCBS PLANS

SOME UHC PLANS

SOME AETNA PLANS

The fee for the refraction is \$65.00. Refraction fee for all other insurances will be collected at the time of the visit. If your insurance company is listed above, we will bill your insurance company first. If they do not pay for the refraction you will be billed.

Payment for the applicable co-payment(s), deductible(s), and non-covered services are due on the date of service. There will be an additional \$25.00 charge if payment is not received at time of service

If you cancel or no show an appointment 2 or more times without a 24-hour notice, there will be a charge of \$50.00.

In an effort to provide you with flexible payment arrangements, we have expanded our payment policy. We now offer the following payment options: (EXCLUDING REFRACTION AND COPAY WHICH MUST BE PAID IN FULL AT TIME OF VISIT)

_____ **Payment by Cash, Check, or Credit Card**

_____ **Automatic Monthly Billing to your Credit Card**

_____ **Pre Auth any amount not covered by insurance with your Credit Card
(Deductible and Co-Insurance)**

Please make your choice, sign below and return to reception before treatment. If none of the above apply, please ask to speak with a billing representative.

I have spoken with a representative of this practice and understand fully that I am responsible for all amounts not covered by my insurance.

X

Patient Signature or Authorized Party

X

Date

The Center for Eye Care and Optical Signature on File, Assignment of Benefits, Financial Agreement

BENEFICIARY NAME:

Account #

1. MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to The Center for Eye Care and Optical for services furnished me by The Center for Eye Care and Optical. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. The Center for Eye Care and Optical accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

2. MEDIGAP: I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to The Center for Eye Care and Optical, if possible or otherwise to me.

3. RELEASE OF INFORMATION: The Center for Eye Care and Optical may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to The Center for Eye Care and Optical for reimbursement for services rendered, and (2) any health care provider for continued patient care. The Center for Eye Care and Optical may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

4. OTHER INSURANCE: I understand that The Center for Eye Care and Optical maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office. And that The Center for Eye Care and Optical has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by The Center for Eye Care and Optical if I belong to a plan that does not appear on the above-mentioned list.

5. NON-COVERED SERVICES: I understand that The Center for Eye Care and Optical contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services which are covered by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patients contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with The Center for Eye Care and Optical to obtain necessary health care service plan authorizations.

6. FINANCIAL AGREEMENT: I agree that in return for the services provided to the patient by The Center for Eye Care and Optical, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to The Center for Eye Care and Optical for payment. If an account is sent to an attorney for collection, I understand that if my account is delinquent, I agree to pay collection expenses which are currently 30% of all outstanding fees as well as the reasonable attorney's fees as established by the court and not by a jury in any court action. Any benefits of any type under any policy of insurance, insuring the patient, or any other party liable to the patient, is hereby assigned to The Center for Eye Care and Optical. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to The Center for Eye Care and Optical. *However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.*

X

Patient Signature or Authorized Party

X

Date