NEW EYES

Patient Name: _____ Date of Birth: _____

FINANCIAL AGREEMENT

Thank you for choosing **New Eyes** as your eye care provider. The following is our Financial Policy which will help you with your concerns regarding our billing and payment procedures.

Payment for services is due at the time service is rendered. We accept cash, money orders, debit cards, credit cards. **IF YOU HAVE A CO-PAY, IT WILL BE COLLECTED AT THE TIME OF SERVICE** **You are responsible for knowing your insurance benefits! If you are an HMO member, you are responsible for obtaining referrals/authorizations from your PCP and/or carrier.** Patients are responsible for deductible balances, co-insurances, and **non-covered** amounts at the time of service. Any billed balances are due within 30 days of the statement date.

Please have **ALL INSURANCE CARDS** and a **PHOTO ID** **AVAILABLE FOR PHOTOCOPYING AT ALL TIMES.** Any changes of insurance, address, phone number or emergency contact information should be reported immediately.

Our office participates with most major insurance plans. We provide **MEDICAL and SURGICAL** ophthalmologic care to our patients, as opposed to **routine eye exams**. We do not participate with **ANY** vision plans. **If you have a managed care plan that requires a referral to see a specialist, you must obtain a referral in order for your visit in our office to be covered under your medical insurance. A refractive examination is not a covered service by most insurance companies, including Medicare. If you receive a prescription for glasses, you will be charged $50.00 which is payable at the time of the visit.**

Remember that insurance authorizations/referrals for services DO NOT guarantee payment. There will be a **$25.00** fee for all **returned checks. Should your account become delinquent and be referred to a collection agency, you shall be financially responsible for the costs of collection and/or legal fees.**

I request that payment of authorized Medicare/or any third-party benefits be made to **New Eyes** on my behalf for any services rendered to me. I authorize any holder of medical information about me to release to the Center for Medicare Medicaid Services and its agents or any third-party payor to determine these benefits or the benefits payable for related services.

You will be subject to a $**25.00** charge if you fail to show for any scheduled appointments or cancel with less than two (2) business days' notice before your appointment. Any patient who cancels a scheduled, elective surgery without giving at least **5 business days'** notice prior to surgery, or does not show up for surgery, may be subject to a cancellation fee of **$500.00.** Legitimate emergencies will be taken into consideration. Your doctor is entitled to request compensation from patients for completing most medical forms, and our fee per form is **$20.00** (i.e., FMLA, Disability, FAA, etc.)

Print Patient Name: _____ **Patient/Parent/Guardian *Signature*:** _____

Date of Birth: _____ **Date:** _____

GUARDIANSHIP AND/OR HOSPICE CARE INFORMATION

Does someone have Power of Attorney or legal guardianship for you? ☐ Yes ☐ No

Are you currently under in-patient or out-patient hospice care? ☐ Yes ☐ No

If you answered YES, to either of these questions, please provide us with contact information for the guardian and/or the hospice. New Eyes also needs a **copy of the POA or legal guardianship paperwork** if this applies.

Legal Guardian Name: _____ Signature: _____ Phone: _____

Name of Hospice Services: _____ Case Manager's Name: _____ Phone: _____