The Eye Clinic NJ

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FINANCIAL AGREEMENT

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

PATIENTS MUST FILL OUR PATIENT INFORMATION FORMS PRIOR TO SEEING THE PROVIDER (Doctor). WE WILL REQUIRE A PHOTOCOPY OF YOUR INSURANCE CARD(S) AND PICTURE I.D. FOR YOUR FILE.

- **APPOINTMENTS** – A 24 hour notice must be provided in the event you cannot keep an appointment. Should you not provide this notice; a cancellation fee of $25.00 will then be added to your account. If you do not show for two or more appointments, without 24 hours cancellation, you will be required to leave a $25.00 deposit for all future appointments.
- **REFERRALS** – If your plan requires a referral from your primary care physician, it is your responsibility to obtain it prior to your appointment. If you do not have your referral you will be required to pay for your visit or reschedule at a later date.
- **CO-PAYMENTS** – By law, we MUST collect your carrier-designed co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit.
- **FORMS** – There will be a $15.00 charge for any paperwork that requires filling out.
- **CONTACT FITTING** – There is an $80.00 charge for 1st time wearers for contact lenses. Any Clear Kone fitting will be $100.00. A change in the prescription or lens type for an existing wearer with a change in prescription is $40.00.
- **SELF-PAY PATIENTS** – Patient is expected at the time of service.
- **MEDICARE** – We will submit claims to Medicare. You will be responsible for the deductible and the 20% co-insurance which can be billed to a secondary insurance if you have one.

  Medicare Lifetime Signature on File: I request that payment of authorized Medicare benefits be made on my behalf to The Eye Clinic NJ, (and its agents) any information to determine these benefits payable for related services. This information will be used for the purpose of evaluation and administering claims and benefits.

- **REFRACTIVE SERVICES** – All special refractive lenses, (Restor, Toric, etc) must be paid in full prior to the procedure.
- **DIVORCED/SEPARATED PARENTS OF MINOR PATIENTS** – The parent who consented to the treatment of a minor child is responsible for payment of any fees not paid by the child's insurance carrier. The Eye Clinic NJ, will not be involved with separate ion or divorce disputes.

You are responsible for timely payment of your account.

I UNDERSTAND I AM RESPONSIBLE FOR ANY AND ALL SERVICES NOT COVERED BY MY INSURANCE COMPANY, I ACCEPT RESPONSIBILITY OF MY ACCOUNT.

WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, AMERICAN EXPRESS OR DISCOVER CARDS.

Patient's Name:_____ DOB:_____/_____/_____

Responsible Party Signature:_____ Date:_____

Print Name:_____ Relationship:_____