FINANCIAL AND OFFICE POLICIES ASSIGNMENT OF BENEFITS

Please read and sign in the space provided

✍X_____ **DOB X**_____ **Date X**_____

Print Patient name *I have requested and consent to treatment from Advanced Eye Group, LLC*

*We require you to **bring your INSURANCE card and ID to every office visit.** It is your responsibility to keep us informed of any changes to your address, phone, or insurance information.*

PATIENTS WITH INSURANCE:

- If you do not inform us you have a vision/medical insurance plan(s), we will assume there is none.
- Your insurance policy is a contract between you and your insurance company. **The ultimate responsibility for all charges regardless of what your insurance does/does not pay is yours** including but not limited to deductible, coinsurance or copay.
- We do not guarantee the accuracy of benefit information received by the insurance companies.
- This office, with **NO EXCEPTIONS** will not back date, post authorize, or refund fees after services are rendered due to lack of notification of vision/medical benefits.
- It is your responsibility to obtain any insurance **referrals** (if required) from your primary care Doctor. If a referral has not been obtained PRIOR to your visit, your appointment will be rescheduled (or you may pay out of pocket fees).
- You may file my own claim if you discover you have vision or medical benefits after services/products are rendered.

MINOR/DEPENDENT CHILDREN:

- An adult guardian must be present to sign any legal documents/forms and be able to make decisions on the child's behalf.
- In cases of separation or divorce, that person must be prepared to supply the SUBSCRIBER name, DOB, social security number (or last 4#), address and phone. If we do not have this information, the visit will be out of pocket.

PATIENTS WITHOUT INSURANCE:

- Identification must be presented each visit. Payment is due at the time services are rendered.

AUTHORIZATION TO RELEASE INFORMATION: I authorize the release of any medical information to my insurance carrier or to a licensed physician or health-care provider concerning my illness and treatment. I also request payment of my insurance benefits to Advanced Eye Group, LLC.

★ ***APPROVED HIPAA CONTACTS:*** Except your Doctors, **With whom may we release information to?**

(If the end date is left blank, the duration is indefinite unless revoked in writing.)

Name	Relationship	
_____	_____	○ Billing/Account information
		○ Medical information
_____	_____	○ Billing/Account information
		○ Medical information

★★ ***HIPAA ACKNOWLEDGEMENT:*** I have been presented with the Notice of Privacy Policy of Advanced Eye Group, LLC and have been offered a copy of such policy to keep for my records.

!✍ ❒ **I want a copy of the written policy and have received such.**

❒ **I decline a copy of the written policy**

Signature of patient/guardian X ✍_____

Representative name (if other than patient PRINT) _____

ADVANCED EYE GROUP, LLC.
206 N. Main Rd * Vineland, NJ * 856-691-0720

PROFESSIONAL SERVICES AND FEES

REFRACTION/Vision test: Part of a *Routine* exam **to determine your prescription for the best possible vision.**

- ***NOT* covered by most medical insurances**
- **$40** fee is collected at time of service and is in addition to any copay

As part of the Comprehensive eye exam, ***it is recommended ALL PATIENTS have the internal health of the eye thoroughly evaluated every year.*** This is best done by Dilation or Optomap:

DILATION: eye drops to enlarge the pupils to examine the retina/back of the eye.

- IS COVERED by medical insurances
- Will have blurred vision and light sensitivity for 4-6 hours.

OPTOMAP DIGITAL IMAGING: a high resolution image of the retina/macula. It becomes a permanent part of your medical record for comparison for changes over time.

- NO BLURRINESS OR LIGHT SENSITIVITY
- NOT covered by any insurance
- **$37** fee in addition to any copay and refraction fees.
- Dilation may still be required in some instances.

CONTACT LENSES: are medical devices worn on the eyes.

- Federal regulations require an evaluation and prescription ANNUALLY to avoid infection/injury and to assure the best fit and vision. Federal regulations stipulate a contact lens prescription is valid for 1 year.
- **Evaluation fee** is separate from copay/refraction fees and is collected at the time of service.
  - EVAL: **$39** (same brand/type of lens)
  - REFIT: **$69-$109** (new brand/type of lens)
  - NEW FIT: **$169-$209** Initial fitting and training. Trial lenses and follow ups included.
- Contact lens supply is NOT included.

I understand the above policies/fees and take full responsibility for any activities I may perform after dilation.

Patient name (print) X_____ **Date** X_____

Signature of patient (or guardian) X_____

Representative name (if other than patient PRINT) _____