THE EYE CLINIC NJ

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 A PICTURE I.D. FOR YOUR FILE.

- **APPOINTMENTS:** A 24-hour notice must be provided in the event you cannot keep your 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 up for 2 or more appointments, without 24-hour cancellation, you will be required to leave a $25.00 deposit for all future appointments.
- **REFFERALS:** 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 for 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.
- **REFRACTIONS:** There will be a $50 charge for medical patients. Not covered by medical plans.
- **FUNDUS PHOTOS:** $50 for routine vision plans. Not covered by vision plans.
- **FORMS:** There will be a $20.00 charge for any paperwork that requires filling out.
- **CONTACT LENS FITTING**: There will be a $100.00 charge for 1st time wearer for contact lenses.
- **CONTACT LENS RE-FIT:** There will be a $50.00 charge for a contact lens brand change.
- **SPECIALTY CONTACTS:** There will be a $200 charge for any fit in specialty contact lens.
- **MEDICARE:** You are responsible for the 20% coinsurance/ deductible not covered by Medicare, if you do not have a secondary insurance.

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.

- **DIVORCED/SEPERATED 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 separation 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 and ALL MAJOR CREDIT CARDS including APPLE PAY.

Any Overdue balance over 2 months will result in no appts being made until balance is brought current.

Patient's Name_____ D.O.B: _____/_____/_____

Responsible Party Signature: _____ Date: _____

Print Name: _____Relationship:_____