PATIENT FINANCIAL POLICY

The office policy is to require payment at the time of service by check, cash, or credit card. HMO patients (Blue Choice and MVP) are required by contract to pay the co-payment at the time of service. If you have a high deductible plan, the insurance allowable amount is collected at time of service. .

I acknowledge that I am responsible for knowing my own insurance coverage and presenting my correct, valid insurance card. I acknowledge that my insurance coverage is a contract between me and my insurance company, and the goal of Rochester Eye Associates is to assist me to the best of their ability using the information provided to them. It is my responsibility to provide current, accurate and complete information before receiving services. If the correct insurance information is not furnished at the time of service, Rochester Eye Associates has the right to refuse additional claim submissions.

VISION INSURANCE:
If you wish to have your services submitted to VSP, EyeMed, or MetLife Vision Plan, you must inform REA prior to your appointment. This will allow REA to get required approvals for accurate billing.

CO-PAYMENTS, NON-COVERED PROCEDURES, AND SERVICES CONSIDERED "NOT MEDICALLY NECESSARY:

These monies must be paid at time of service or a $10 fee will be added to your account to cover billing costs.

REFRACTION INFORMATION: A "refraction" is the process of determining the optimal eyeglass prescription for your eyes. This is not only to allow us to prescribe eyeglasses, but more importantly to determine your best corrected vision. The refraction helps us to distinguish whether vision problems are caused by glasses or from eye disease. A refraction may or may not be performed at the time of your visit, depending upon your doctor's judgment of its necessity. This service is not covered by Medicare or by private medical insurance. If a refraction is performed, there will be a fee of $40.00 due at the time of service

Upon ordering contact lenses or eyeglasses, a 50% deposit is due with the balance due at dispensing.

There may be a charge of $25.00 for broken appointments without a 24 hour notification.

ASSIGNMENT OF BENEFITS -- INFORMATION RELEASE
FINANCIAL RESPONSIBILITY -- COLLECTION FEES

I assign all medical / surgical benefits to Rochester Eye Associates, P.C. I further authorize the release of all or any part of my medical record and/or financial ledger to a health insurance agency to secure payment for services rendered or to complete disability forms presented to me. I understand that I am financially responsible for all charges whether or not paid by said insurance agencies. If the amount is referred for collection, I agree to pay for attorney's fees, court costs, and other reasonable costs of collection.

A photocopy of this assignment and authorization is considered as valid as the original. This authorization will remain in effect until revoked in writing.

I have completed this form to the best of my knowledge and understand the policies above.

Signed:

(Patient, Guardian, Responsible Individual)

Date: