

Initials \_\_\_\_\_

### Patient Billing Agreement

1. Some insurance companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. **It is the patient's responsibility to pay any deductible, co-insurance and/or any other balance** not paid by their insurance carrier. Insurance carriers decide what it considers to be medically necessary or routine based on their own criteria. Most insurance carriers do not cover routine eye exams. Therefore we will not bill routine eye exams and patient will be responsible for payment that day. Please check your plan carefully for covered and non – covered services or benefits.
2. In order to control billing costs, we request that patients pay for all known non-covered services at the time of service. **Patients who have an insurance carrier, with which we do not participate,** are required to pay in full at the time of service.
3. Patients with secondary health plans must present proof of insurance on the day of service. If you do not provide proof, you will be responsible to file a claim with your secondary insurance.

### Refraction Policy

1. **Refraction** is a measurement of the lens power necessary to prescribe or change your glasses and/or other corrective lenses. **Refractions** may also be done for diagnostic purposes.
2. Most medical insurance plans, including MEDICARE, **DO NOT COVER A REFRACTION FEE.** If your examination includes refraction, there will be a minimum \$75 charge **DUE THE DAY OF SERVICE** in addition to your co-payment.

### Contact Lens Agreement

1. We are happy to assist you with any contact lens issues you may have. All contact lens services are provided by NewView Eye Center. NewView Eye Center **DOES NOT PARTICIPATE** with any medical insurances or vision plans. **THEREFORE, ANY ADDITIONAL CHARGES RELATED TO CONTACT LENS SERVICES WILL BE YOUR RESPONSIBILITY.**

### Financial Assignment

1. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information as needed to determine these benefits payable for related services.
2. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

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Signature of Patient, Parent or Guardian

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Date