New England VISION

*****OFFICE POLICY*****

Acct: #_____

As a courtesy to our patients, NEW ENGLAND VISION (NEV) will bill your insurance company only if proper information has been provided. In addition, NEV participates with all the contracted insurers and we will bill third party insurers as well. Please refer to your insurance manual for coverage limitations.

Any CO-PAY amount required by an insurance company by the patient will be due **AT THE TIME OF SERVICE.**

MEDICARE DOES NOT PAY FOR REFRACTIONS. **SUPPLEMENTAL INSURANCES TO MEDICARE AND PRIMARY INSURANCE CARRIERS may pay and we will bill them. However, if ANY insurance company denies coverage for the refraction, YOU will be responsible for that charge which is $35.** A **REFRACTION** IS THE PORTION OF THE EXAM WHERE A PIECE OF EQUIPMENT IS PLACED IN FRONT OF YOUR EYES TO SEE IF YOUR VISION CAN BE IMPROVED WITH A CHANGE IN YOUR LENSES.

I assign to the doctor all money to which I am entitled for expenses relative to the services performed. It is understood that any money received from the insurance company over and above my indebtedness will be refunded to me when my bill is paid in full. I understand I am financially responsible to the doctor for all charges regardless if I have insurance or not.

I consent to the use or disclosure of my **Protected Health Information** by NEV for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of NEV. I have the right to revoke this consent, in writing, at any time, except to the extent that NEV has taken action in reliance on this consent.

My "**Protected Health Information**" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Print Name of Patient or Personal Representative Date