
ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of GREENE COUNTY EYE CARE, INC., Notice of Privacy Practices.

Date _____ Patient name_____Signature _____

INSURANCE ASSIGNMENT POLICY/ADVANCED BENEFICIARY NOTICE AND WAIVER

Our office is happy to accept your insurance assignment. However, it is the responsibility of the patient to learn and understand their insurance coverage in full. If you feel unsure that you are able to provide full insurance information at the time of service, please reschedule your appointment to a later date when you will be able to provide all needed information.

The following is a statement of our policy concerning insurance claims:

1. We are willing to bill your insurance, but it is necessary that you provide us with full and complete information for any and all policies that may cover you. Due to HIPAA privacy laws, we cannot access, check, or verify insurance information you do not provide to us. This includes policies carried by a spouse or parent, or any secondary or additional plans you do not provide to us today.

2. Any and all copays (the amount not covered by your insurance) will be paid at the completion of your exam today.

3.Insurance payments are typically received within 30 to 60 days of the date of service. If an insurance company has not made payment to us within 90 days, we may request payment for the full balance to be made by the patient. The patient then may seek direct reimbursement from the insurance company.

4. Medicare Recipients: Medicare does not cover the cost of the refraction, the portion of the exam in which your glasses prescription is determined. The patient will be responsible for the refraction cost of $25.00.
Medicare may cover a portion toward the cost of glasses one time after cataract surgery. In all other cases, frame or lens claims will be denied.

5. Contact Lens Wearers: Please be advised that our office charges a fee for all contact lens exams. This fee is a contact lens fitting fee and the charge is $45-$125, it is not covered by insurance and is the patient's responsibility to pay on the date of service.

6. Our office will not enter into child custody disputes. If a minor child is treated with us, the individual who brings the child for service will be held responsible. We will bill necessary insurance. Please have all divisions of payment arranged in advance so payment can be made on the date of service.

7. Our office does not guarantee that an insurance company will pay. We will perform our routine insurance billing procedures upon verification of coverage. If the patient's insurance claim is denied, the patient will be responsible for the full amount of the bill.

If you understand and agree with the above stated policies, please sign and date below and we will accept your insurance assignment.

_____ _____

Signature of patient or guardian Date