Long Island Ophthalmic Care, P.L.L.C.

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Financial Responsibility Form

We strive to give you the best possible care. In order to serve this purpose, it is important that you understand the mechanisms of reimbursement. Please read this Financial Responsibility Form and sign at the bottom to acknowledge that you understand your accountability.

INSURANCE COVERAGE – It is your responsibility to be aware of your insurance coverage, policy provisions, exclusions and limitations as well as authorization requirements. This information is obtained by contacting your insurance carrier. We attempt to verify that your coverage is valid at the time of the visit. However, if your coverage is not in effect that that time of the visit, the financial responsibility for payment is yours. If you have had any changes in your insurance coverage – even if there is only a small change in the co-payment amount or a change in the expiration date of the policy – you must notify us. Even a small discrepancy on the claim form can lead to the claim denial.

CO-PAYMENTS, CO-INSURANCES AND DEDUCTIBLES – Co-payments and co-insurances are your responsibility. Your insurance company expects us to collect them from you at the time of service. Understand that you will be expected to pay your co-payment for each and every date of service. You are also responsible for your deductibles. The deductible is determined by your individual contract with your insurance carrier. We do not have information about each person's deductible amount, and how much of that has been met. You will be responsible for finding out all information about your deductible prior to your appointment with our office.

REFERRALS AND/OR AUTHORIATIONS – Many insurance carriers require pre-authorization and/or a referral for each visit with us. You are responsible for obtaining these referrals or authorizations. You may need to work with your primary care provider of your OB/GYN doctor in order to obtain this. Contact your insurance carrier if you have any questions regarding what type of services require pre-certification.

INSURANCE PAYMENTS SENT TO YOU – If insurance payments are sent to you erroneously, you are responsible for forwarding them to our office.

NON-COVERED SERVICES – All patients are responsible if their insurance carrier denies payment for services rendered because they were "non-covered services." These non-covered services may include certain treatment types, bloodwork, supplies, equipment, etc. To avoid this, please check with your insurance carrier prior to receiving any treatment.

I have read and fully understand this Financial Responsibility Form. I acknowledge my personal financial responsibility and I consent to continue this treatment.

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Patient or Authorized Representative's Signature **Date**