

BILLING POLICIES

The best medical care can be provided only on the basis of mutual understanding. We encourage you to discuss any questions you may have regarding our policies with our billing staff.

By signing this form, I am acknowledging that:

- It is my responsibility to provide complete and correct insurance/billing information including presentation of a current insurance card to Ramapo Ophthalmology Associates. This also includes effective start and termination dates. I understand that failure to do so may result in denial of benefits from my insurance carrier. In this event, I understand that I shall be responsible for services rendered by Ramapo Ophthalmology Associates.
- I am responsible for any co-pays, co-insurance, and deductibles required by my insurance plan. I understand that payment will be made at time of service. If payment is not made at time of service I understand an additional administrative fee will be added. **Payments made by credit/debit card are subject to an additional 3.79% bank service fee.**
- Eyeglasses Prescription – I understand that my medical insurance will not pay for an eyeglasses prescription. This is an out of pocket expense. If I request a prescription I will be expected to pay for the prescription regardless if there is any change in my prescription and my insurance status.
- I understand that Ramapo Ophthalmology Associates participates with Medicare. This means we accept the fees set by Medicare for medical/surgical services covered by the Medicare program. Medicare patients will be responsible for co-payments, co-insurance, deductibles and any non-covered services, such as refractions and routine eye exams or for premium services categorized as "non-covered" by Medicare.
- I am responsible for providing a referral or necessary authorization needed to be seen at Ramapo Ophthalmology Associates. I understand if proper documentation is not provided I will be responsible for the cost of my visit.
- A **\$75 fee** will be imposed for any missed appointments, no shows, or late (less than 24 hour) cancellations of office visits. This will not be covered by my insurance.
- For any overdue balances greater than 30 days, 6% interest will be applied to the total balance due. If the bill is not paid within 3 months it will be forwarded to collections.
- A fee of up to \$100 may be imposed for any outside forms or letters that need to be completed {i.e. DMV forms, housing expenses, employment forms, etc}, copies of medical records and other administrative requests.
- I understand that before any surgical procedure or exam which may entail greater expense, our office will provide insurance coverage information and estimate what, if any, balance may remain once insurance has paid. At your request, we will provide information on coverage to the best of our ability for any examination or procedure we perform, even when not of great expense. Payment of any balance is expected prior to the surgery/procedure date. If special financial circumstances warrant an extended payment plan, our staff will be glad to help you.
- I understand that contact lens evaluations/fittings are performed by our optometrist. Contact lens evaluations/fittings are an out of pocket expense, not covered by my medical insurance. Cost of the evaluation and fitting are due at the time they are rendered.

Signature _____ Date _____



3 Medical Park Drive
Pomona, NY 10970
Tel: 845-362-1450
Fax: 845-362-3830
www.ramapoeyecare.com

***In consideration of services to be provided to me or my dependent, I hereby assign, transfer, and set over to Ramapo Ophthalmology Associates all rights, title and interest to reimbursement benefits under my insurance policy(s), including any and all major medical benefits. I understand that I am financially responsible to Ramapo Ophthalmology Associates for charges not covered by this assignment. Initial _____

***I certify that I am the patient. If I am not the patient, I certify that I am duly authorized as the patient's general agent to execute the above and accept its terms. I acknowledge that a copy of this consent will be provided to me upon request. Initial _____

*** I understand that it is my responsibility to provide Ramapo Ophthalmology Associates with my current insurance and provide a copy of the card. In the event my insurance changes and I have not presented the correct insurance information/card to our office you may be responsible for out of network rates for all charges. Initial _____

***I understand my insurance may charge a diagnostic co-payment that our office may not be aware of. In the event that your insurance indicates your responsibility, you will be charged for the diagnostic co-pay. Initial _____

***I understand that having active insurance does not guarantee that my insurance will cover claims submitted. In the event a claim is denied, I am responsible for full payment of claim. Initial _____

***I understand if in the event, it is determined that my insurance benefits are cancelled or rescinded I am fully responsible for all charges. Initial _____

*** I understand there may be charges for services that are "non-covered" by any insurance company. If there are such charges, I am fully responsible to make full payment upon receipt of statement from Ramapo Ophthalmology. Initial _____

*****EXAM FOR EYEGASSES***** Major medical insurance plans, including Medicare, **do not** cover the exam for an eyeglass's prescription/ This office will charge \$80.00 fee for this service **unless** performed by Dr. Richard Gordon the fee will be \$100.00 plus any co-payments that apply. This fee is subject to change. Initial _____

Patient's Signature (Parent/Guardian Signature if Minor)

Date



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*****EXAM FOR EYEGLASSES*****

GLASSES/ CONTACT LENS PRESCRIPTION

Dear Patient,

If you request an eyeglasses prescription check, the fee for this examination is **\$80.00** unless performed by Dr. Richard Gordon, the fee will be **\$100.00**. If you request to update your contact lens prescription, the fee for this examination is **\$85.00** or **\$100.00**, respectively. These are considered **non-covered** charges by medical insurance.

Major medical insurance plans: Medical insurance plans including Medicare, **do not cover** the exam for an eyeglass's prescription.

Vision Plan Coverage: If you have vision plan coverage, you may be able to receive this service at a participating provider. **We do not participate** with any vision plans. **You will be responsible for the charges if you request this service.**

These payments are expected at the time of service.

Please sign this form in **acknowledgement** that you are aware that there is a fee for this examination.

Signature

Date

Printed Name



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INFORMATION REGARDING DILATING EYE DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time, which varies from person to person, and may make bright light bothersome. It is not possible for your ophthalmologist to predict how long your vision will be affected. Driving may be difficult immediately after an examination. It is best if you make arrangements **not** to drive yourself.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize the physicians of Ramapo Ophthalmology Associates, LLP, and/or such assistants as may be designated by the physicians to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

Patient Signature (or person authorized to sign for patient)

Date



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I request that payment of authorized insurance benefits be made to Ramapo Ophthalmology Associates, LLP, or any physician associated with Ramapo Ophthalmology Associates, LLP, for any services provided to me by that physician(s). I authorize any holder of medical information about me to be released to my insurance company and its agents, any information needed to determine these benefits payable for related services.

Signature: _____

Date: _____

Written Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____

Date of Birth: _____

I _____, hereby acknowledge that I have been offered a copy of the notice of privacy practices. I understand that if I have further questions or complaints I may contact: Ramapo Ophthalmology Associates, 3 Medical Park Drive, Pomona, NY 10970. I also understand that I am entitled to receive updates upon request if Ramapo Ophthalmology Associates' notice of privacy practices is amended or changed in a material way.

Signature: _____ Date: _____

Signature: _____ Personal Representative: _____ Date : _____
(if patient is unable to sign)

Permission to Disclose Medical Information to Family Members

I give permission for Ramapo Ophthalmology Associates to disclose any necessary medical information with the following family members if I am unable to discuss the information personally. I also understand that ONLY the family members below will be given my medical information if a situation warrants it.

Name: _____ Relationship to Patient: _____

Signature of Patient: _____ Date: _____