FAMILY VISION ASSOCIATES

YOUR VISION IS OUR FOCUS™

Financial Policy & HIPAA Privacy

Financial Policy

This financial agreement is intended to facilitate our ability to provide excellent service while informing you of your financial obligation to our practice.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that, as your vision care provider, our relationship is with you, not with your insurance company. Your insurance policy is a contract between you, your insurance company, and/or your employer. Our office is not a party to that contract. If payment from your insurance company is not received within 90 days from the date of service, you will be expected to pay the balance in full.

IF YOU DO NOT HAVE INSURANCE: Payment is due in full at the time service is provided.

PAYMENT:

Our office accepts cash, personal checks, MasterCard, Visa, Discover, American Express, Apple Pay and Android Pay. Outside financing is available through CareCredit upon request and approval. Returned checks and balances older than 30 days will be subject to collection fees and finance charges at the rate of 1.0% per month (12% annually). If at any point there is a credit on your account, you may apply the credit towards future services, or a refund check will be issued to you upon request. Refund checks will automatically be sent when the credit amount is above $15.00.

IF YOU HAVE INSURANCE: As a courtesy to you, we will help you process all of your insurance claims. Your estimated co-payment for services, which is the amount not covered by your insurance, is due at the time service is provided. Your co-payment may be adjusted after the time of service depending upon the final reconciliation of insurance payments.

INSURED PATIENTS – PLEASE READ CAREFULLY:

The amount of coverage paid by your insurance company may be based on your insurance company's own reduced fee schedule for services and may be less than actual charges, resulting in lower coverage to you. We have no control over this situation and cannot be held responsible if an estimated co-payment is less than what the insurance company actually pays on the claim. Lower payment is a direct result of the plan selected by **you or your employer**. Furthermore, any estimate of coverage provided to us by your insurance company represents an estimate only and never constitutes a guarantee of payment. As such, we too can never guarantee payment on a claim. In no way is Family Vision Associates LLC. to be held liable for any non-payment of claims by your insurance company. You, as the insured, bear the ultimate financial responsibility in covering the financial cost of all services rendered. Please be advised that **WE CANNOT WAIVE ANY CO-PAYMENTS.** We are required **BY LAW TO COLLECT YOUR CO-PAYMENT.**

Medical Versus Vision Insurance

We often have patients that have both vision and medical insurance. They are very different in terms of the services covered and it is important for our patients to understand those differences. Vision coverage is mainly designed to determine a prescription for glasses, help pay for eyeglasses or contact lenses, and to evaluate eye health. Vision coverage is not designed or equipped to deal with medical conditions, diagnoses or treatment plans. When a medical diagnosis or condition is present (such as high blood pressure, diabetes, or an eye disease such as infections, dry eyes, allergies, or cataracts), it may be necessary to file the claim with your major medical carrier. The co-pays and/or deductibles will apply, as well as any fees for non-covered services. Vision insurance does not cover medical eye problems and

medical insurance may not cover routine vision exams. Our office does not make these rules; the insurance carriers define them.

Reproduction of Records

In accordance with the NJ Consumer Affairs, we will reproduce a patient's records upon written request by the patient or other authorized representative for a minimum fee of $10.00. If the records requested exceed ten (10) pages then we will instead charge $1.00 per page, or $100 for the entire record, whichever is less.

Notice of Privacy Policies – Patient Acknowledgement

1. I have received or reviewed the Notice of Privacy Practices. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, and the practice's legal duties with respect to my information.
2. I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at or controlled by this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.
3. I designate the persons listed on my online form as individuals involved in my healthcare and authorize this practice to discuss private health information as well as discuss financial information regarding payment with Family Vision Associates. I understand that I may change this list at any time by submitting a written request. *(Family Vision Associates will not be allowed to discuss **anything** with anyone that you do not list below even if they are calling on your behalf.)* 4. I designate the phone numbers also listed on my online form where Family Vision Associates can contact me to receive or discuss private healthcare information and/or payment information.

Refraction Charge for Medicare

The refraction is not covered under the Medicare program, but is one of the most frequent and important tests performed by the doctor. Under Medicare, the beneficiary is responsible for paying this fee, which we collect at the time of service for all patients. If we receive payment on the refraction from your insurance company our office will reimburse you.

Cancellation Policy:

Should you be unable to keep your appointment, please call the office no less than 24 business hours prior to your appointment to cancel. **Missed appointments may be subject up to a $50.00 fee.** This fee is not reimbursable by your insurance company. If you are running late, but plan on keeping your appointment, out of courtesy to us and other patients, call the office ASAP. We will do our best to adjust our schedule accordingly.

By signing below, I confirm that I have read, understand and agree to the above statements.

Patient/Guardian Signature: _____