Billing and Financial Policies

Insurance Authorization and Assignment: I request that payment of authorized private insurance company benefits, Medicare and Medicaid services or other applicable benefits be paid on my behalf to Dr. Laliberté of Main Street Optometry for any furnished services. I authorize Main Street Optometry to release any medical or other information about me to any private insurance company, Medicare and Medicaid or other company and its agents, which might provide coverage to me.

All Services are the Responsibility of the Patient: Main Street Optometry will gladly bill your primary insurance. I understand that insurance benefits must be determined prior to my exam and that eligibility verification does not guarantee coverage once the claim is filed. If I become aware of insurance coverage after services have been rendered, I agree to personally submit the claim to my insurance company for reimbursement. I understand that when my insurance company requires a referral from my primary-care physician and I do not furnish the correct referral at the time of service, I will be responsible for payment if my insurance company refuses my claim. I also understand and acknowledge that I am financially responsible for non-covered services and any unpaid insurance balance over 45 days past due.

Payments, Co-Pays and Deductibles are Due at Time of Service: I understand that not all services and material may be covered by my insurance or may exceed benefits or coverage. I agree to pay all payments, co-pays and deductibles at the time of service for all services and materials. ***During the exam**, **the doctor may find a medical diagnosis** (such as cataracts, diabetes, dry eye syndrome, etc.) If this occurs, your exam may no longer be considered a **"routine eye exam" and would no longer be able to be billed to your routine vision insurance.** The health portion of your exam would then be **billed to your medical insurance**, and the refraction (the finding of your glasses prescription) would be out of pocket. **The refraction charge is $29.00**.*

Returned Checks: There is a $25.00 fee for any check returned by the bank. This fee will be added to the unpaid balance and must be paid by cash or credit card.

Patient Name:_____(please print)
Responsible Party
(if not the patient)_____(please print)

Signature:_____ Date:_____

ACKNOWLEDGEMENT RECEIPT

By initialing below, I acknowledge I was offered a copy of Main Street Optometry's Notice of Privacy Practices.
_____Yes, I would like to receive a copy of Main Street Optometry's Notice of Privacy Practices.
_____No, I do not wish to receive a copy of Main Street Optometry's Notice of Privacy Practices

Due to HIPAA regulations - If you are over 18 years of age, please list any authorized person(s) with whom we can discuss your appointments, insurance and/or payments with (i.e. spouse, parent, etc.)

Name of Authorized Person(s): Relationship to Patient:

_____ _____

_____ _____