FAMILY VISION CARE

Stephen A. Kowalsky, O.D.

Financial Policy Statement

To help our patients fully understand our billing process, we ask that you read and sign our financial policy statement.

As a courtesy to you, Family Vision Care will submit a claim to your insurance carrier. Depending upon your individual policy, your coverage, your deductible and/or co-payment requirements, you may be billed for the balance.

Although Family Vision Care participates with most insurance carriers, it is your responsibility at the time of service to verify with your insurance carrier if our office or the service/test that you are scheduled to have is accepted by your plan.

There are two types of health insurance that will help pay for your eye care services and optical products. You may have both types and Family Vision Care accepts most insurance plans in both categories:
1) Vision Plans (Such as VSP, EyeMed, Davis, and others). Vision plans only cover routine vision wellness exams, along with eyeglasses and contact lenses.
2) Medical Insurance (such as Blue Cross/Blue Shield, Medicare and others). Medical insurance must be used for medical eye care (the diagnosis, management or treatment of eye health problems).

If you have both types of insurance plans it may be necessary for us to bill some services to one plan and some services to the other. We will follow a procedure called coordination of benefits to do this properly and to minimize your out-of-pocket expense. You may incur a secondary copay for services submitted to your major medical plans.

For claims not submitted, Family Vision Care accepts cash, checks, debit, credit cards and Care Credit for payment. For insurance plans that do not allow courtesy submission of claims, you must pay at the time of service.

When our Doctor participates fully in your insurance plan, you are still responsible for paying any co-insurance, deductible or co-payment (s) as indicated by your carrier, as well as any non-covered service(s) under your contract. Once payment has been made or payment has been denied by the insurance company you will be billed and be responsible to pay the balance.

You are responsible for bringing the necessary referral(s) to the office on the day of your appointment. If you do not have the required referral form(s) on the day of the appointment, you are responsible for payment at that time. Whoever, (parent, grandparent, babysitter or legal guardian, etc.) accompanies a minor to his/her appointment is expected to pay at the time of the service.

Although Family Vision Care may on occasion, file private insurance claims, we will not become involved in disputes between you and your insurance carrier regarding covered charges, secondary insurance issues or "usual and customary" charges other than supply factual information as required by the insurance carrier.

A $50 service fee will be imposed on any returned check. If you do not pay for the amount of the returned check and fees, we will file a complaint with the proper authorities and you will be responsible for all fees incurred in the filing. A collection fee representing 1/3 of the outstanding balance will be added if the account is referred to an attorney or collection agency.

We charge $0.50/page to copy records. We will process the copies within 30 days of the receipt of your signed request.

We will refund over-payments to the responsible party within 30 days once all outstanding claims are paid.

Please provide your insurance cards, and a photo ID (drivers license or government issued ID) to our staff member so we can make a copy. We need to have your medical insurance card or Medicare card on file in case we should need it in the future for billing your insurance.

MEDICAL RELEASE/LIFETIME SIGNATURE ON FILE/PAYMENT AUTHORIZATION

I authorize payment for all insurance benefits for services rendered by this office be made payable to Dr. Kowalsky/Family Vision Care.

I authorize Family Vision Care to release any information necessary to determine the benefits payable for related services to the appropriate insurance agencies. I permit a copy of this authorization to be used in place of the original. This form will serve as a lifetime signature form.

I understand that some insurance companies (including Medicare) do not pay for the refractive part of the examination. If refraction (the part of the exam that determines your need for eyeglasses) is necessary, these insurance carriers will deny the claim, stating that it is not a covered Medicare/Insurance benefit. Therefore, the patient will be responsible for the refraction charge as well as for any other "non-covered" services.

I hereby give my consent for me or my child to be seen. I understand that my eyes may be dilated during examinations.

I have read and understand the terms of this document. I have had an opportunity to ask questions about the use or disclosure of my health information and about the contents of this form. I acknowledge, consent and agree to the terms and conditions of this document.

Responsible Party Signature_____**Date**_____

21 Lafayette Road, Suite C - Sparta, NJ 07871 - Telephone (973) 729-7755 - Fax (973)729-0677 - www.kowalskyfamilyvisioncare.com