FAMILY VISION CARE

Stephen A. Kowalsky, O.D.

Insurance Information & Financial Policy

In order for us to bill on your behalf and collect payment from you insurance company, you must authorize us to do so by filling out this form completely and signing

PRIMARY MEDICAL INSURANCE

Name of primary insured:_____

Primary Insured's DOB:_____

Social Security #_____

Insurance Company:_____

Relation to Patient (please circle):

Parent/Guardian Spouse Domestic Partner Self

SECONDARY INSURANCE

Name of primary insured:_____

Primary Insured's DOB:_____

Social Security #_____

Insurance Company:_____

Relation to Patient (please circle):

Parent/Guardian Spouse Domestic Partner Self

*VERIFICATION OF BENEFITS OR COVERAGE *IS NOT* A GAURANTEE OF ELIGIBILITY OR *PAYMENT*. ACTUAL PAYMENT IS BASED ON TERMS AND CONDITIONS OF YOU PLAN AT THE TIME OF INSURANCE PROCESSING.

*AS A COURTESY WE WILL *TRY* TO CONTACT *YOUR* INSURACE COMPANY FOR ELIGIBILITY STATUS. IT IS *YOUR* RESPONSIBILITY TO MAKE SURE *YOU* HAVE COVERAGE FOR THE DATE OF SERVICE THOUGH *YOUR* INSURANCE. *

*PATIENT IS RESPONSIBLE FOR OBTAINING ANY NEEDED REFERALS FROM THEIR PCP. IF NO REFERAL IS PROVIDED AT TIME OF SERVICE PATIENT OR GUARDIAN IS RESPONSIBLE FOR FULL PAYMENT *

*THERE IS A *FEE* FOR CONTACT LENS FITTING OR EVALUATION OF YOUR CURRENT CONTACT LENSES WHICH MAY OR *MAY NOT* BE COVERED BY INSURANCE*

FAMILY VISION CARE IS *NOT* ON PAR WITH ANY MEDICAID PLANS

* THERE IS A CHARGE OF $1/PAGE TO COPY RECORDS. WE PROCESS RECORD REQUESTS WITHIN 30 DAYS OF RECIEPT OF SIGNED REQUEST*

MEDICAL RELEASE/ LIFETIME SIGNATURE ON FILE/ PAYMENT AUTHORIZATION

- I authorize use of this form on all my insurance submissions.
- I authorize release of information to all my insurance companies.
- I authorize my doctor to act as my agent in helping me obtain payment from the insurance company.
- I authorize payment to be made to the above mentioned doctor(s)/practice.
- I permit a copy of this authorization to be used in place of the original.
- I understand that I am responsible for any balance after insurance processing.
- I understand that some insurance companies (including Medicare) do not pay for the refractive part of the exam (this part of the exam is necessary to determine your need for glasses). These insurance carriers will deny the claim, stating that it is not a covered benefit. Therefore, the patient will be responsible for the refraction, as well as any other "non-covered" services
- I understand that failure to pay after 30 days will result in an 18%/yr finance charge
- I understand that there is a $50 service fee on any returned checks. Failure to pay or untimely payments of returned checks and fees will resort in the claim being filed with an attorney and/or collection agency resulting in a additional collection fee of $50.

Print Name:_____

Signature:_____

Date:_____

***Please note, there is a $50 No Show fee for appointments NOT canceled within 24 hours.*
*There is a $100 No Show fee for any testing NOT canceled within 24 hours.***