612 University Avenue
Syracuse, NY 13210
Phone (315) 422-2020 Fax (315) 422-7339

Notification of Financial and Practice Policies

Patient's Name *(print)* _____ Policy/Subscriber ID (Insurance) _____

PATIENT RESPONSIBILITY:
We will answer questions relating to your insurance to the best of our ability, however, your insurance is a contract between you and your insurance carrier. It is your responsibility to know the terms of your coverage.

We will do our best to verify your eligibility at the time of service, however, you or your responsible party accept responsibility for any and all charges deemed not eligible for coverage by your insurance carrier. You may also request that we do not bill your insurance coverage for certain services; however payment in full for those services must be made at the time services are provided.

CHECK-IN/REGISTRATION PROCEDURES:
It is your responsibility to bring your insurance card(s) to all appointments and present them at time of check-in. Your appointment may be rescheduled if your insurance card(s) is not provided at the time of service.

REFERRALS and PRE-AUTHORIZATIONS:
You as the patient/responsible party must obtain any authorization or referral required by your insurance carrier for services provided by our Practice. You understand that failure to do so could result in additional out-of-pocket expenses. Referrals MUST be present at the time of your appointment or your appointment will be rescheduled.

MEDICARE:
If you are a Medicare beneficiary, you certify that the information given by you for payment under Medicare is correct. You request that payment of authorized Medicare benefits be made payable to Syracuse Eye Center for any services furnished to you by the Practice. You give permission to the Practice to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine benefits or the benefits payable for services or to obtain payment of any claims relating to these services.

MEDIGAP:
I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Syracuse Eye Center, if possible or otherwise to me.

RELEASE OF INFORMATION:
Syracuse Eye Center may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to Syracuse Eye Center for reimbursement for services rendered, and (2) any health care provider for continued patient care. Syracuse Eye Center may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

INSURANCES WE ARE CONTRACTED WITH:
If we participate with your insurance carrier, we will bill your insurance carrier for you. You, the patient or responsible party, are responsible for payment of your co-payment, co-insurance and/or deductible at the time of service. You are, by signing below, assigning your insurance carrier to make direct payment to our Practice.

SEE OTHER SIDE*

INSURANCES WE DO NOT PARTICIPATE WITH:
If we do not have a signed contract with your insurance carrier and we are a non-participating provider, your status will be "self-pay" and you will be required to pay for your care at the time of service. We will courtesy bill your insurance company and refund you any payments made by your insurance carrier on your behalf. If you do not want us to courtesy bill, you may have a copy of the charges and codes associated with your care and you may submit these to your insurance carrier for reimbursement directly to you from your insurer.

SELF-PAY:
You understand that by not providing proof of insurance (a valid insurance card) or by requesting that your insurance carrier not be billed, charges for services are your responsibility. Payment in full is due at the time of service. Self-pay amounts due may be settled by credit or debit card or cash. We do not accept checks for self-pay services.

NON-COVERED SERVICES:
I understand that Syracuse Eye Center contracts with health care service plans (i.e., HMOs, PPOs) state items and services that are "covered" by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Syracuse Eye Center to obtain necessary health care service plan authorizations.

FINANCIAL AGREEMENT:
I agree that in return for the services provided to the patient by Syracuse Eye Center, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Syracuse Eye Center for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to Syracuse Eye Center. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Syracuse Eye Center. ***However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.***

DUTY TO INFORM:
You acknowledge that it is your responsibility to notify the Practice of changes to your contact information (address, phone number), primary & specialty physicians and health care providers involved in your care, responsible party for payment and changes in insurance coverage or carriers. Failure to do so could adversely affect the care you receive and the necessary communication of treatment information to your primary physician.

WRITTEN ACKNOWLEDGEMENT OF FINANCIAL AND PRACTICE POLICIES:
You acknowledge that you have received and had an opportunity to ask questions concerning the Practice Policies of Syracuse Eye Center. You agree to the terms and conditions contained herein.

_____ _____
Patient's Signature Date

_____ _____
Responsible Party Relationship to patient