NEW JERSEY VISION ASSOCIATES, P.C. PAYMENT POLICY (1/1/17)

NJ Vision Associates has a responsibility to provide quality healthcare services to our patients. In the interest of maintaining a good doctor-patient relationship, we ask that you take responsibility for your financial obligation to our practice. Our policies have been established for our patients and include, but are not limited to, the following:

1. **Insurance:** NJ Vision will file claims for all applicable visits and procedures. You are responsible for payment of all deductibles, coinsurance, copayments, and all non-covered services. Please remember that insurance coverage is a contract between the patient and the insurance company. The ultimate responsibility for payment of services rendered rests with you.
2. **Referrals and Prior Authorizations:** You are required to 1) know whether or not your insurance requires a referral for medical and/or surgical treatment and 2) obtain that referral before you are scheduled to see Dr. Vogel. Our office will assist you in determining whether Dr. Vogel is a participating or non-participating provider. However, this is not a guarantee of coverage. Referrals typically have an expiration date and a limited number of visits; it is your responsibility to monitor your referral status. Our office will not see a patient who does not have a valid referral.
3. **No Insurance:** Patients who do not have insurance are expected to pay in full for services rendered. Payment in full is due the day the services are rendered. We accept payment with cash, check or credit card (Amex/Visa/Mastercard/Discover). We understand that individual situations may make it difficult to meet these financial obligations and we are happy to discuss other payment arrangements as needed. You must make these arrangements before services are rendered.
4. **Returned Checks:** Your account will be charged $50 for each returned check. You will be asked to provide payment by cash or credit card for the total cost of the returned check and the $50 fee.
5. **Past Due Accounts:** Patients who have not made an effort to make payment arrangements or have not met their financial obligations will be turned over to our collection agency after 90 days past due. Once an account has been sent to collections, the patient must contact the collection agency for all correspondence regarding the balance. NJ Vision is authorized to automatically collect payment via credit card for any past due balance when credit card information is on file.
6. **Non-Covered Services:** NJ Vision will make a concerted effort to inform you if we believe a service may not be covered by your insurance company. In our professional judgment, these services are needed to render high quality medical care even though they may not be covered by insurance. You will be expected to pay for such services, even if your insurance company denies payment. We will file to medical insurance if appropriate.
7. **Appointment Cancellations and No Shows:** As a courtesy to our patients on the waitlist, if you need to cancel or reschedule your appointment, please give our office **at least 24 hours notice** of your scheduled appointment. **Failure to give proper notice of cancellation or failure to show for your appointment may result in a charge to your account of $50.** If this happens, our office reserves the right to keep your credit card on file if you wish to reschedule. Thank you for your consideration.

I have read the above payment policy. I understand my responsibilities for payment of services rendered and will fulfill my financial obligations for services rendered at NJ Vision Associates.

_____

Patient Signature Date

REFRACTION POLICY

The doctor performs a refraction to determine your eyeglass prescription. The refraction is also necessary in order to rule out certain eye problems. The refraction test occurs when our staff shows you a variety of corrective lenses and asks you to say which lens makes the images being viewed better or worse. A refraction is an essential part of a complete and comprehensive eye examination, but is **NOT** a covered service by most medical insurance plans regardless of why the doctor performs the test. Please be aware that if this service is performed during your examination, a refraction charge of **$50** will be collected today in addition to your copayment.

ACKNOWLEDGEMENT:

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service. I understand the copayment is separate from, and not included in, the refraction fee. I understand I will only be charged this fee when a refraction is done during my examination.

_____

Patient Signature Date

Rev: 1/1/2020