Norwich Ophthalmology GROUP
You'll see the difference.

Patient Name_____

Date of Birth_____

Medicare: We accept Medicare assignment. As a Medicare patient you are responsible for your deductible and the difference between the allowable charge and the amount Medicare pays. You are also responsible for refraction fees as they are a Medicare non-covered service. If you have supplemental insurance we will bill it for you. Any remaining balance will be your responsibility.

HMO/PPO/Commercial: All co-payments and account balances are due at time of service. You are responsible for verifying what your insurance plan will cover and that we are participating providers in your plan.

Self-Pay: A minimum of $50 is due at the time of service for all self-pay patients. Any subsequent visit charges will be due at the time of service.

Workers' Compensation: If you are here as a result of work related injury we will require information regarding both health insurance and your employer's Workman's Compensation insurance. We will require a claim number, insurance address, adjuster's name and phone number. If payment is not received, the balance is your responsibility.

____ (INITIAL) I understand that I may be liable for the full amount of services provided, if I have not provided accurate and correct information within the TIMELY FILING LIMIT set by my insurance carrier. TIMELY FILING LIMITS are as little as 60 days from the date of service.

____ (INITIAL) I understand that my insurance company may pay less than the actual billed services and I am responsible for any charges that the insurance carrier deems a "non-covered service" and assign responsibility of payment to the patient/guarantor.

____ (INITIAL) I understand that if my insurance company requires an electronic referral from my Primary Care Physician (PCP) prior to seeing a specialist, it is my responsibility. It is also my responsibility to obtain a new referral when a previous one has expired or I have surpassed the allowed number of visits. My insurance carrier determines when a referral is required.

____ (INITIAL) I understand that it is my responsibility to verify what services my insurance company will cover and that Norwich Ophthalmology Group, P.C. and its physicians are participating providers in your plan.

____ (INITIAL) Unpaid balances that remain outstanding may be turned over to a collection agency. I realize failure to keep this account current may result in my being discharged from the practice.

____ (INITIAL) I understand in case of default in this account, I agree to pay collections costs and reasonable attorney fees incurred in attempting to collect on this amount or any future account balances.

____ (INITIAL) I understand that I may be charged $25.00 for each missed "No Show" appointment that is not cancelled within 24 hours of my appointment time. This fee is not covered by insurance and must be paid prior to your next appointment. Multiple "No Show" appointments may result in termination from the practice.

HIPAA Acknowledgement: I understand that I have rights regarding my protected health information. These rights are governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I have been informed of and been given the opportunity to review and secure a copy of Norwich Ophthalmology Group, P.C. Notice of Privacy Practices, which contains a more complete description of the uses and disclosure of my protected health information. I understand that Norwich Ophthalmology Group, P.C. complies with the Public Act No. 08-167 concerning the confidentiality of social security numbers.

Release of Information: I authorize my physician, health care provider, and their representative to release any information relating to an illness, injury, diagnosis, or care of treatment to my insurance company, health plan, or third party payer or their agents, contractors, subcontractors, or affiliates provided they agree such information is kept confidential. Such information shall include, but is not limited to, any medical records and medical information. I understand that the reason for furnishing such information may include the following: for use in medical, financial, and or provider auditing or such other auditing as may be legally required for utilization and/or quality of care review and assessment and of determining available health benefits and coverage.

PLEASE SIGN ACKNOWLEDGEMENT OF THE ABOVE FINANCIAL STATEMENT, HIPAA AND RELEASE OF INFORMATION ACKNOWLEDGEMENT

I attest I have disclosed all active insurance and agree the proper information is on file with my provider. I understand if the insurance information is incorrect, I will be responsible for payment.

Signature _____ Date _____