Family Vision Care
Dr. Chaulaben Patel
21 Lafayette Road, Suite C
Sparta, NJ 07871

Insurance Information & Financial Policy Agreement

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:

PRIMARY INSURANCE

Name of primary insured:_____
Primary Insured's DOB:_____
Social Security #_____
Insurance Company:_____
Relation to Patient _____
Relation to Patient _____

SECONDARY INSURANCE

Name of primary insured:_____
Primary Insured's DOB:_____
Social Security #_____
Insurance Company:_____
Relation to Patient _____
Relation to Patient _____

- ☐ Verification of benefits or coverage is not a guarantee of eligibility or payment. Actual payment is based on terms and conditions of your plan at the time of insurance processing.
- ☐ As a courtesy we will try to contact your insurance company for eligibility status. It is your responsibility to make sure you have coverage for the date of service though your insurance.
- ☐ We are not responsible for obtaining any needed referrals from your primary care provider. If no referral is provided at time of service, the patient or guardian is responsible for full payment .
- ☐ The fee for contact lens fitting and evaluation of your current contact lenses may not be covered by insurance.
- ☐ Family Vision Care does not accept any Medicaid plans.
- ☐ Record requests will be processed within 30 days of receipt of the signed request. There is a charge of $1 per page to copy records.

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FAMILY VISION CARE

CANCELLATION / REFUND / RETURN POLICY

No refund can be made on clinical procedures or services, including comprehensive eye examination, refraction, contact lens fitting fees, and medical office visits.

Eyeglass products, which include frames, lenses, and coatings, cannot be canceled or refunded, as these are custom made to order products.

Unopened boxes of contact lenses can only be returned within 30 days of receiving the product, provided that the product is returned to the store without damage at the time that the refund is issued. A restocking fee (20% of the retail price) will apply to any contact lens material returns. Opened, marked, or damaged boxes of contact lenses are non-refundable.

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% per month 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 result in the claim being filed with an attorney and/or collection agency resulting in an additional collection fee of $50.
- ☐ I understand that there is a $25 No Show fee for appointments canceled without 24 hours notice.

Signature:_____

Print Name:_____ Date:_____

Revised 3.23.2023