new era eyecare OPTOMETRISTS

HIPAA BILLING AND PAYMENT POLICY

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(Patients Last Name) (Patients First Name)

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(Name of Primary Member on the Insurance)

No Insurance Coverage: We take most insurance plans. If yours is not one that we currently participate with, or if you do not have insurance, full payment must be made at the time of your exam/purchase. If you discover that you do have vision insurance after the date of service, a $30 reprocessing fee will be deducted from the difference once your insurance is applied. There will be a $50 fee for any checks returned by your bank.

Eyeglasses and Contact Lenses: Full payment (*after insurance and discounts*) is due at the time of sale before an order can be placed. No eyeglass remakes will be permitted for prescriptions obtained from online exams. Limit one remake for any outside provider's prescription change. Contact lens orders/contact lens prescriptions are not released until the contact lens evaluation fee is paid in full.

Returns and Restocking Fees: *Eyewear returns after lenses/frames have been ordered are subject to a 30% restocking fee. No Eyewear or contact returns will be permitted after 45 days. Unopened contacts purchased in this office are subject to a 20% restocking fee when exchanged or returned. There is a $25 fee if a patient chooses to use their own frame. We are not responsible for any damage during processing of patient's frames not purchased at this location.*

Authorization to Leave Messages: I authorize employees of New Era Eyecare Optometrists to email my medical records to the following e-mail address upon my request. I acknowledge the information will be sent unencrypted. I authorize New Era Eyecare Optometrist to speak with any person listed below on my behalf, messages may include some protected health information including appointment reminders, test results, instructions and information.

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I have read, understand, and agree to the above billing and payment policy. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles are my responsibility. I understand that it is my responsibility to contact my insurance company carrier on a timely basis if they do not respond to payment requests made on my behalf. I authorize New Era Eyecare Optometrists to release pertinent medical information to my insurance company when needed to obtain authorization for services or materials and or medical procedures, or to facilitate the payment of a claim. I authorize my prescription information to be sent to optical labs for processing of materials, or to another doctor whose treatment I am receiving. I authorize New Era Eyecare to release my medical information to public health authorities in the event of allergic reactions to medical products or medicines, communicable diseases or domestic/drug abuse.

My signature indicates that I have read and agreed to the policies above. I understand that through my signature I have authorized the release of oral or written communication by the staff of New Era Eyecare Optometrists to the above phone number and/or e-mail address.

Signature _____ Date _____

Contact Lens Patients: Sign below to acknowledge that you were provided with a copy of your contact lens prescription at the completion of your contact lens evaluation

Signature _____

***Notice of Privacy Policies:** As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).