https://www.facebook.com/BroadwayEye

https://twitter.com/bernerburesheye

Broadway Eye Clinic Financial Policy

1. I understand all office charges and co-pays are due at the time of service by cash, check, or credit card. Broadway Eye Clinic will glad bill my health or vision insurance for services that my insurance authorizes. If the services billed to my insurance are denied, I am responsible to pay upon receipt of the bill in a timely matter.
2. I acknowledge and agree that an interest rate of 1 ½ percent per month (18% annum) will be charged on all balances that remain unpaid 30 days after said date of service. In the event of default and referral an attorney or collection agency, I agree to pay all collection costs including reasonable attorney fees.
3. I understand Medicare and other health or vision insurances will only pay for services they are obligated under law or under contract to provide. If Medicare or any other insurance denies payment for reasonable service allowed by law, I understand I am liable for payment of that service.
4. I understand that if I am under Medicare insurance, Medicare does not pay for refraction code 92015. I agree to be personally and fully responsible for payment for that service. I also understand that Medicare does not pay for optical materials (frames, lenses, or contacts) unless immediately after cataract surgery. I agree to pay all material charges, which are allowable, and Medicare does not pay. This includes additional charges for more expensive frames and lenses that I may desire after cataract surgery.
5. I understand that all optical products (glasses and contacts) are custom orders. If I should cancel an order after the manufacturing of the product has started, I will still be liable for the charges.
6. I agree to provide Broadway Eye Clinic with my insurance card so they may copy it for insurance billing information. I understand if I don't provide my insurance card they may be unable to bill my insurance.
7. I consent for Broadway Eye Clinic to use or disclose my health information for treatment, payment and healthcare operations. I have had the opportunity to review the Broadway Eye Clinic Privacy Practices consistent with U.S. law and acknowledge that I have been offered a copy of these Privacy Practices.
8. I understand I am entitled to a copy of my contact lens prescription or glasses prescription. I authorize Broadway Eye Clinic to maintain these prescriptions in my medical record and understand that I may request a copy at any time.

PATIENT SIGNATURE:_____DATE: _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and print your name.

RELATIONSHIP TO PATIENT:_____PRINT NAME:_____

Dr. Reviewed _____