833-509-OCLI
(833-509-6254)

OCLI VISION

ocli.net

FINANCIAL POLICY

Thank you for selecting our office for your eye care. In order to prevent any misunderstanding concerning the responsibility for payment for medical and surgical care, the following information is necessary for you to read and understand prior to you being seen by your physician.

The patient or the guarantor is responsible for payment **at the time of service**. The only exception is if your doctor is a participating provider of your private, state, or federal insurance program. In this case, we will accept the insurance payment as payment in full ONLY after all deductibles have been met and all co-pays have been paid.

HMO/PPO Coverage

If you have insurance through a company that your doctor has contracted with, we will require a copy of your insurance card, the mailing address for your insurance company, and **payment of any co-pays that are due at the time of service**. If your insurance carrier requires a referral from your primary care physician, this must be presented prior to being seen by the doctor. Failure to provide all the necessary information may require you to reschedule your appointment. It is your responsibility to keep track of the referral expiration date and the number of visits given by your primary care physician.

Medicare

Most of OCLI's physicians participate in the federal Medicare program. Medicare will pay 80% of the approved charges after you pay your annual deductible. As the patient, you will be responsible for your 20% coinsurance.

Do You Want a Full-Vision Refraction (Prescription for Glasses/Contact Lenses)?

If you do, we must perform a REFRACTION. Refraction is the procedure that a trained ophthalmic professional performs to determine a person's exact eyeglass or contact lens prescription. This is a SEPARATE service performed at the time of your eye examination, which is not always covered by insurance. If your insurance does not pay for refraction, $50 will be due at the time of service. If the fee is billed to your insurance carrier and denied as a non-covered service, you will be responsible for the $50.

YES, I want to have a new prescription for eyeglasses and/or contact lenses.

By signing below, I understand that I will be charged $50 if my insurance does not cover this service.

No, I do not want to have a new prescription for eyeglasses and/or contact lenses.

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Assignment of Benefits

I request that payment of authorized Medicare/Medicaid/private insurance company benefits be made on my behalf to Ophthalmic Consultants of Long Island for services furnished to me by the provider. I authorize my provider or his/her designee to release to CMS, NYS Medicaid program, or any insurance program or company through which I am entitled to benefits coverage, or agent thereof, any information needed to determine benefits or the benefits payable for related services.

I HAVE READ THE ABOVE AND AGREE THAT I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT FOR ANY SERVICES.

_____	_____	_____
Signature of Patient	Print Name	Date of Birth
_____	_____	_____
Signature of Insured or Responsible Party	Print Name	Date