454 Elizabeth Avenue
Suite 220
Somerset, NJ 08873

Financial Responsibility

ABOUT YOUR INSURANCE There are two types of health insurance that may help pay for your eye care services and materials. You may have both and our practice accepts both: 1) Medical Insurance (such as Blue Cross/Blue Shield and Medicare) and, 2) Vision Insurance (such as VSP and EyeMed). Vision insurance only covers ROUTINE VISION EXAMS along with eyeglasses and contact lenses. **Medical insurance must be used if you have any eye health problem that has ocular complications**. Our doctor will determine if these conditions apply to you but some are determined by your case history. Most medical insurance plans do have routine vision screening benefits but these are very different from an actual vision examination. Vision screenings are basic screenings for eye disease. *They do not cover diagnosis, management or treatment of eye diseases nor do they allow for a prescription to be written for eyeglasses or contact lenses*. If you have both types of insurance plans, it may be necessary for us to bill some services to one plan and other services to the other plan. We will use coordination of benefits to do this properly and to minimize your out-of-pocket expense. We will bill your insurance plan for services if we are a participating provider for that plan. We will try to obtain advanced authorization of your insurance benefits in an attempt to let you know what is covered. Any co-pays, deductibles or non-covered services will be your responsibility.

We will be happy to file your insurance claim forms with your medical/vision benefits as designated by: _____(Medical) and/or_____ (Vision)

Plan(s) of which you state you are a member. We will do all we can to help you receive maximum benefits. However, in the event that the plan sponsor determines that you are not eligible for coverage at the time of service, or makes a determination that you are eligible for a reduced level of coverage, by signing this statement you hereby agree to be financially responsible for any and all charges incurred by you and not paid by the plan sponsor.

Assignment of Benefits Authorization and Release of Medical Information. I authorize all payments from my insurance carrier to be made directly to Franklin Family Eyecare. I certify that the information I reported with regard to my insurance coverage is correct. I further authorize the release of any information for this or any related claim to my insurance company, and will permit a copy of this form to be used in place of the original.

I have read and understood the office financial policies and agree to the conditions above and further agree that I, as the patient receiving services or the responsible party for the patient, am ultimately responsible for payment of any materials ordered and/or services rendered.

Patient: _____ Date: _____

Signature of patient or person acting on patient's behalf