NEW YORK LASER VISION
Medical and Surgical Eye Care
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Statement of patient financial responsibility:

New York Laser Vision appreciates the confidence you have shown in choosing our ophthalmology practice to provide for your vision care needs. The service(s) you have elected to participate in implies a financial responsibility on your part. It is your responsibility and absolute obligation to ensure payment in full for our fees. As a courtesy, we will make every effort to obtain accurate information from your insurance carrier, if any, and verify your insurance coverage and your insurance carrier on your behalf. However, please note that verification of benefits and acceptance of assignment of your insurance benefits is not a guarantee that your insurance carrier will pay our claims in full.

> **YOU ARE ULTIMATELY RESPONSIBLE FOR THE PAYMENT IN FULL OF THE FEES FOR SERVICES RENDERED TO YOU BY NEW YORK LASER VISION!**

INSURANCE IS ACCEPTED UNDER THE FOLLOWING CONDITIONS ONLY: You are responsible for payment of any co-payment at the time of service and promptly upon receipt of a bill for any deductible/coinsurance as identified by your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. **You are responsible for any amount not covered by your insurer.** You agree to pay all deductibles, coninsurance, copayments, fees (in full) for non-covered services and other fees deemed "patient responsibility" by your insurance carrier upon adjudication of the claim submitted on your behalf for the services rendered to you by New York Laser Vision. You are fully and solely responsible for obtaining any necessary referral(s) from another physician(s) prior to your appointment date and providing such referral(s) to our office at the time of your appointment. Please note that any claim payment(s) denied due to lack of a referral become the patient's responsibility.

I have read the above policy regarding my full financial responsibility to New York Laser Vision for services provided to me (or the above named patient). I certify that the information provided is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to New York Laser Visions. I agree to pay New York Laser Vision the full and entire

amount of all bills incurred by me (or above named patient); or if applicable, any amount due after payment has been made by my insurance carrier

CO-PAYMENT POLICY:

Some health insurance carriers require the patient to pay a co-pay for healthcare services rendered. In accordance with the applicable laws and regulations, it is the policy of our practice that **co-payments are paid in full at the time of the visit.** Your full cooperation is appreciated.

Deductible Policy:

Credit Card on File and Electronic Agreement:

All patients with private insurance are required to leave a credit card on file.
Patients must sign an electronic agreement authorizing New York Laser Vision to charge the credit card on file for deductible payments and any other applicable fees.

Deductible Deposit for Regular Visits:

Patients are required to pay a $200 deposit toward their deductible for each regular visit until their deductible is met.
This deposit will be collected at the time of the visit.

Procedure and Pre-Op Testing Fees: Different fees may apply for patients coming in for procedures or pre-operative testing. The specific fees will be communicated to the patient prior to the scheduled procedure or testing.
Meeting the Deductible: Once the deductible is met, patients will no longer be required to pay the $200 deposit for regular visits. Any overpayments made toward the deductible will be refunded or applied to future services, as appropriate.

CONTACT LENS/GLASSES FEE AGREEMENT

Contact lens fittings and prescriptions are commonly not covered by medical insurance. As a result, you will be responsible for any fees associated with receiving contact lenses.

The contact lens fitting fee is $125.00.
You do not receive your final contact lens prescription on the first day of your fitting as there is a mandatory trial period of at least 1 week to test out the comfort and fit of your contact lenses before finalizing your prescription.
If you have astigmatism, there is an additional $50 fee as the trial contact lenses must be ordered custom-made for your astigmatism by our office (an additional visit is required to fit you with them when they arrive). You will be contacted by our office when your contact lenses have arrived so that you may schedule your appointment.

Fee for standard contact lens fitting: $125
Fee for contact lens fitting with astigmatism: $175
Fee for multifocal contact lenses fitting (for distance and reading): $175
Fee for contact lens re-fitting, or updating your prescription: $50

The cost of the contact lenses is NOT included in this price and you must order them separately after receiving the finalized contact lens prescription.

GLASSES PRESCRIPTION

Patients with certain private insurances that do not cover the cost of refraction may be billed $50.00 by our office AFTER the entire visit claim is processed by the insurance.