FALL RIVER VISION

DR. D. POSNER • OPTOMETRIST

Dear Patient:

I would like to take the time to personally thank you for choosing us as your healthcare provider. I realize you have many options for eye health and eye wear. I hope I can help you in your journey towards improved health, by offering you a thorough eye examination and accurate prescription as part of your evaluation. We hope this eye examination will be the best you have ever had, and that you will again look to us for your and your family's eye care needs in the years to come. Thank you on behalf of myself, Dr. Douglas S. Posner, and the staff at Fall River Vision.

Assignment and Release

I authorize payment of benefits directly to Fall Vision for services rendered. I also authorize release of any medical information that may be required in determination of such benefits.

I understand that some services may require prior approval or a referral from my primary care physician for coverage and that, if I do not obtain that approval or referral, I am financially liable for the services.

I understand that my insurance carrier may not cover some services and products. Also, that benefit information does not constitute approval of payment. Fall River Vision has a high standard of care and offers patients premium technology to fulfill that standard. During your exam you will have retinal photos as part of every routine exam. Also all patients over 18 years of age will have automated visual field screening preformed. These services will be submitted to you insurance carrier. If this presents a problem please ask for a waiver form. Deductibles and fees not paid by my insurance carrier will be my responsibility. I also understand that there will be no refunds for rendered professional medical services related to eye exams, contact lens fittings or evaluations. Due to policy provisions in your insurance contract with your insurance carrier, and under the terms of the federal anti-kickback laws, we are legally prohibited from writing off deductibles, patient responsibility, co insurance as directed by your insurance carrier, or co-payments.

Also, if your policy is an out of network policy with our office and the provisions of your insurance mandates that allowable benefits are to be issued to you, the patient, rather than the provider of service, we will require payment at the time of service.

I acknowledge full responsibility for all charges not covered by my insurance carrier. I understand that all balances are payable within 30 days from the date of service or a 1.5% monthly charge will be assessed. I will be responsible for all additional charges if my account is sent to a collection agency for non-payment.

We sincerely regret if any of these regulatory provisions cause you any inconvenience, but we must be bound by all provisions of insurance policy and federal law.

Signature_____ Date_____
If under 18, Signature of responsible party above.

I acknowledge that I received a copy Fall River Vision's "NOTICE OF PRIVACY, HIPPA" policy.

Signature_____ Date_____
If under 18, Signature of responsible party above.