BELLMORE
2450 Merrick Road
Bellmore, NY 11710
(516) 783-0300

GREAT NECK
560 Northern Boulevard
Great Neck, NY 11020
(516) 504-2020

HUNTINGTON
158 Main Street
Huntington, NY 11743
(631) 427-1690

LITTLE NECK
54-44 Little Neck Pkwy
Little Neck, NY 11362
(718) 428-9393

FINANCIAL POLICY

Dear Patients:

Thank you for choosing our Practice to provide your ophthalmologic needs. We will do our best to provide you with the finest possible medical care and attentive patient services. In order to prevent any misunderstanding concerning the responsibility of payment for medical and surgical care, the following information is necessary for you to read and understand prior to being seen.

The patient or the guarantor is responsible for payment at the time services are rendered. The only exception is if our doctor is a participating provider. In this case, we will accept the insurance payment as payment in full ONLY after all deductibles have been met and all co-pays and coinsurance have been paid.

If your insurance carrier requires a referral from your primary care physician, the referral 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: Dr. Tung is a Medicare Participating provider. Medicare will pay 80% of the approved charges AFTER YOUR YEARLY DEDUCTIBLE HAS BEEN MET. According to Federal Law, You are required to pay your deductible and the 20% balance if you do not have a secondary insurance carrier that will cover this cost.

HMO/PPO COVERAGE: If you have insurance through a company that our doctor has contracted with, we will require a copy of your insurance card, and **payment of any copays are due at the time of service.**

NON COVERED SERVICES: Some services we render may not be covered by your insurance carrier. Your signature below indicates that you have advised our doctor to proceed with the service and that you assume full responsibility for payment. These services may include (but are not limited to), contact lenses, refractions which may be needed to determine if any medical, optical or surgical treatment may be needed.

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

_____ _____

Signature of Patient or Guarantor Date

_____ _____

Signature or Responsibility Party (Guardian/Parent) Date

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