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Wantagh, New York 11793
516-785-3900 • Fax: 516-783-0033

South Shore Eye Care

689 Broadway
Massapequa, New York 11758
516-541-4141 • Fax: 516-541-4150

WELCOME TO OUR PRACTICE!

Thank you for choosing us as your eye care provider. The physicians and staff at South Shore Eye Care, LLP are dedicated to providing you with the best possible care and services. We have adopted the following financial policies in order to minimize confusion or misunderstanding between our patients and the practice:

Self-Paying Patients: Payment for services is due when services are rendered. If we do not participate in your insurance plan, we will be happy to help you process your insurance claim for reimbursement once all fees are paid.

Participating Insurance: You must provide us with *accurate* insurance information and allow us to photocopy your insurance card. Any co-payments are due at the time of service. You are ultimately responsible for knowing the requirements and coverage limitations of your own insurance policy. If a referral is required by your plan, it must be presented prior to services. You must ensure that the referral is made to the correct doctor, that it has not expired and that the number of visits have not all been utilized. If you receive specialty services without obtaining a required referral, you will be financially responsible for such services. It is your insurance carrier's responsibility (as required by NYS Insurance Law) to pay us for services covered by your contract within 45 days from date of receipt. If your carrier does not comply with the law, we may transfer the responsibility to you.

Medicare and most other insurance companies do not cover the examination for and prescribing of glasses as part of an eye examination. This service is called **REFRACTION.** If you require this examination, our fee is $60.00.

I have read and fully understand the policies of this office regarding payments and insurance. I agree to pay for services and tests not covered by my insurance plan and understand that I am responsible for following my insurance plan's regulations, policies and procedures.
I request that payment of authorized Medicare benefits be made either to me or on my behalf to Drs. Stein, Benjamin, Luchs, Flicker, Lane, or their associates, (South Shore Eye Care, LLP) for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

I also request that this authorization apply to any other insurance. I authorize the release of any medical or other information necessary to process this claim as well as payment of medical benefits to the above physician for services rendered.

Payment Responsibility

I understand that co-payment required by my insurance provider is due at the time of service and that I am financially responsible for **ANY** and **ALL** amounts not paid by my insurance carrier.

I understand that my account will be subject to an **ADDITIONAL PROCESSING FEE EACH MONTH** if payment is not received at the time of service.

Patient/Parent or Guardian signature _____

Patient Name _____ Date _____