NVISION EYE CENTERS

+1(877)91-NVISION
+1(877)916-8474
www.NVISIONCenters.com

PAYMENT POLICY

Name: _____ **Date of Birth:** _____

BASIC POLICY:

Payment for service is due in full at the time service is provided in our office.

PATIENTS WITH INSURANCE:

LASIK/REFRACTIVE SURGERY Is NOT A COVERED BENEFIT FOR MOST INSURANCE PLANS

Some treatments are billable to insurance, while others are not. NVISION doctors are contracted with Medicare and selective private insurances. If you have OUT-OF-NETWORK benefits and your NVISION provider is not contracted with your carrier, payment is due in full at the time of service. If we are not contracted with your insurance company, you have the ability to submit a claim to your insurance provider and NVISION will supply you with the necessary information to do so. NVISION does not guarantee that your insurance provider will reimburse for services rendered. NVISION is not responsible for denied insurance claims.

For NVISION Eye Institute patients, we will bill most insurance carriers for you if proper paperwork is provided to us. We will also bill most secondary insurance companies for you. Co-payments and deductibles are due at the time of service. We can only bill for surgeon fees. You must contact the facility where your surgery is performed and inform them to bill facility fees, anesthesia, etc. on your behalf. We cannot guarantee that the facility is in network with your individual insurance company. You must contact the facility prior to your surgery to verify services will be covered. Since your agreement with your insurance is a private one, we do not routinely research why an insurance carrier has not paid or why it has paid less than participated for care. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full by you.

NON – COVERED SERVICES:

Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

ASSIGNMENTS OF INSURANCE BENEFITS:

I authorize the release of any medical information necessary to process my insurance claim(s). I authorize and request payment of medical benefits directly to my physicians. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me. I agree that a photocopy of this form may be used in lieu of the original. I understand I am financially responsible to NVISION for the charges incurred.

Have you met your deductible for the calendar year?	☐ Yes	☐ No	☐ Not Sure
Are you currently employed?	☐ Yes	☐ No	
Are your injuries accident related?	☐ Yes	☐ No	
Did you sustain an injury at work?	☐ Yes	☐ No	
Have you ever served in the military?	☐ Yes	☐ No	
Are you covered under an employer or union policy?	☐ Yes	☐ No	
Is your spouse or other family member employed?	☐ Yes	☐ No	
Do you have a secondary insurance policy?	☐ Yes	☐ No	
Are you covered under any other healthcare plan?	☐ Yes	☐ No	

I have read, understand and agree to the above financial policy for payment of professional fees. I understand that I am ultimately responsible for all professional fees.

_____ _____

Signature of patient (if over 18) or patient's parent of legal guardian Date

_____ _____

If signed by parent of legal guardian, print name Relationship