Hillsborough Eye Care

Dr. Sam Lee & Associates

601 Rt. 206, Unit 36 - Hillsborough, NJ 08844

We are pleased to welcome you to Hillsborough Eye Care, please take a moment to fill out the questionnaire given below as accurately as possible. These questions will help us have a preliminary insight into attending to your eye care needs with efficiency and professional care.

Insurance Information

Medical Insurance

Policy Holder's Last Name _____ First Name _____ MI ____

Insured DOB ___/___/___ Patient Relationship to Insured: Self [ ] Spouse [ ] Child [ ] Other [ ]

Address (if different from patient) _____

City _____ State _____ Zip _____

Employer's/Business _____ Occupation _____ Phone _____

Insurance Company _____ Group # _____ Subscriber ID# _____

Vision Plan

Policy Holder's Last Name _____ First Name _____ MI ____

Insured DOB ___/___/___ Patient Relationship to Insured: Self [ ] Spouse [ ] Child [ ] Other [ ]

Address (if different from patient) _____

City _____ State _____ Zip _____

Employer's/Business _____ Occupation _____ Phone _____

Insurance Company _____ Group # _____ Subscriber ID# _____

About Your Plans

Two types of health insurance may help pay for your eyecare services and materials. You may have both and our practice accepts both. If you have both types of plans, it may be necessary for us to bill some services to one plan and other services to the other plan. We will always let you know and use coordination of benefits to do this properly and to minimize your out-of-pocket expenses.

- Vision Plans (i.e., VSP and EyeMed): Vision plans are discount plans that typically cover annual eye exams along with benefits for eyeglasses and contact lenses. However, they do not cover the diagnosis, management, or treatment of eye diseases.
- Medical Insurance (i.e., Blue Cross Blue Shield and Medicare): Your doctor will assess whether these factors apply to your situation. Medical insurance must be used for eye health problems with ocular complications. Your doctor will determine if these conditions apply to you and some are determined by your case history. Medical insurance plans may also have routine vision benefits.

Billing Policy

As a courtesy, Hillsborough Eye Care ("HEC") will verify your benefits with your insurance or vision plan company. However, it is ultimately the patient's responsibility to be aware of their applicable insurance deductibles, copayments, and coinsurance before receiving services. Payment for services are due at the time of service unless prior financial arrangements have been made and are non-refundable.

A benefits quote is not a guarantee of coverage or payment. If the insurance processes the claim differently than quoted, the insurance company will adhere to their plan's terms and may not honor the benefit quote we received. If your health insurance or vision plan covers you and our office is in-network, we will submit claims directly to your insurance provider. Please provide your insurance information to the front office staff for verification.

Once HEC submits a claim to your insurance or vision plan for services rendered, we will receive an Explanation of Benefits (EOB) detailing any payments made directly to the doctor, claims applied to your deductible, and/or any applicable copayments or coinsurance. If a claim is applied toward the deductible, or if copayment or coinsurance is required, we will bill you for the amount specified on the EOB. You are responsible for any outstanding balances, including additional copayments, deductibles, or charges for non-covered services. If a credit is due, we will issue a prompt refund.

An account is considered delinquent when insurance has not been paid within 30-45 days after HEC's billing or if payment in full has not been received within 30 days of the final insurance payment. Delinquent accounts can be assessed penalties and interest at the annual rate of 12%, and such accounts may be turned over to a collection agency. I further agree that in the event legal action is required in order to enforce payment on this account, I will pay all court costs, expenses, attorney's fees, and other costs incurred and/or expended as a result of such proceeding.

Please note that our services may not be covered by your insurance plan. A referral from another physician does not guarantee insurance coverage for our services. You are fully responsible for all charges incurred. Your physician's referral and our insurance verification do not guarantee payment.

I certify that I, and/or my dependent(s), have coverage with the insurance plan(s) provided and hereby assign all insurance benefits, if any, payable to me for services rendered, directly to Dr. Sam Lee O.D. and Associates. I understand that I am financially responsible to HEC for any charges not covered by insurance and will pay any remaining balance. I authorize the release of necessary information to secure payment of benefits and consent to the use of this signature on all insurance submissions.

× _____ **Date**_____

Signature of Patient, Parent, Legal Guardian or Personal Representative

Medicare Authorization

I hereby request that payments of authorized Medicare benefits be made either directly to me or on my behalf to Dr. Sam Lee O.D. and Associates for any services provided at Hillsborough Eye Care.

By signing below, I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents any information necessary to determine my benefits or the benefits payable for related services. I understand that my signature authorizes both the payment of benefits and the release of medical information required to process the claim.

If “other health insurance” is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms, including electronically submitted claims, my signature further authorizes the release of relevant information to the insurer or agency listed.

In cases where Medicare assigns benefits, I understand that the physician or supplier agrees to accept the Medicare carrier's charge determination as the full charge for the service. I am responsible only for any deductible, coinsurance, and services that are not covered by Medicare. The deductible and coinsurance amounts will be based on the charge determination made by the Medicare carrier.

I acknowledge that the fee for refraction is not covered by Medicare and will be billed separately. If a secondary insurance policy covers the refraction fee, I understand I will be reimbursed accordingly.

× _____ **Date**_____

Signature of Patient, Parent, Legal Guardian or Personal Representative