833-509-OCLI
(833-509-6254)

OCLI VISION

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# FINANCIAL POLICY

Thank you for selecting our office for your eye care. In order to prevent any misunderstanding concerning the responsibility for payment for medical and surgical care, the following information is necessary for you to read and understand prior to you being seen by your physician.

The patient or the guarantor is responsible for payment **at the time of service**. The only exception is if your doctor is a participating provider of your private, state, or federal insurance program. In this case, we will accept the insurance payment as payment in full ONLY after all deductibles have been met and all co-pays have been paid.

## HMO/PPO Coverage

If you have insurance through a company that your doctor has contracted with, we will require a copy of your insurance card, the mailing address for your insurance company, and **payment of any co-pays that are due at the time of service**. If your insurance carrier requires a referral from your primary care physician, this 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

All of OCLI's physicians participate in the federal Medicare program. Medicare will pay 80% of the approved charges after you pay your annual deductible. As the patient, you will be responsible for your 20% coinsurance.

## Do You Want a Full-Vision Refraction (Prescription for Glasses/Contact Lenses)?

If you do, we must perform a REFRACTION. Refraction is the procedure that a trained ophthalmic professional performs to determine a person's exact eyeglass or contact lens prescription. This is a SEPARATE service performed at the time of your eye examination, which is not always covered by insurance. If your insurance does not pay for refraction, $50 will be due at the time of service. If the fee is billed to your insurance carrier and denied as a non-covered service, you will be responsible for the $50.

☐ **YES,** I want to have a new prescription for eyeglasses and/or contact lenses.

By signing below, I understand that I will be charged $50 if my insurance does not cover this service.

☐ **No,** I do not want to have a new prescription for eyeglasses and/or contact lenses.

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**Assignment of Benefits**

I request that payment of authorized Medicare/Medicaid/private insurance company benefits be made on my behalf to Ophthalmic Consultants of Long Island for services furnished to me by the provider. I authorize my provider or his/her designee to release to CMS, NYS Medicaid program, or any insurance program or company through which I am entitled to benefits coverage, or agent thereof, any information needed to determine benefits or the benefits payable for related services.

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

| _____ | _____ | _____ |
|---|---|---|
| Signature of Patient | Print Name | Date of Birth |
| _____ | _____ | _____ |
| Signature of Insured or Responsible Party | Print Name | Date |

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# NOTICE OF PRIVACY PRACTICES

**Patient Name:**
**Patient DOB:**

1. **THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.** This notice is provided in two layers: This first layer briefly summarizes how we handle your health information; the second layer is a full copy in greater detail of our privacy policies and procedures and is prominently posted in our waiting room, at our webpage, and copies of which are available and provided to you at our front desk.

2. **How we may use and disclose your health information.** We use health information about you for treatment, to get paid for treatment, for administrative purposes, and to evaluate the quality of care that you receive. For example, your health information may be shared with other providers to whom you are referred. Information may be shared by paper mail, electronic mail, fax, or other methods. We may use or disclose your health information without your authorization for several reasons. But beyond those situations, we will ask for your written authorization before using or disclosing your health information. If you sign an authorization to disclose information you can later revoke it to stop any future uses and disclosures.

3. **Your rights.** In most cases, you have the right to look at or get a copy of your health information that we use to make decisions about you. If you request copies, we may charge you a cost-based fee. You also have the right to request a list of certain types of disclosures of your information that we have made. If you believe your health information is incorrect or information is missing, you have the right to request that we correct the existing information or add the missing information.

4. **Our legal duty.** We are required by law to protect the privacy of your health information, provide this notice about our privacy practices, follow the privacy practices that are described in this notice, and seek your acknowledgment of receipt of this notice. We may change our privacy policies any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area. You can also request a copy of our notice at any time. For more information about our privacy policies, contact the person listed below.

5. **Privacy complaints.** If you are concerned that we have violated your privacy rights, our privacy policies, or if you disagree with a decision we made about access to your health information, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

This document covers OCLI Vision and all of its affiliates.

**If you have any questions or complaints, please contact:** Privacy Officer for OCLI Vision, 825 East Gate Boulevard, Suite 111, Garden City, NY 11530 (516) 804-5200.

**Acknowledgment of receipt of Notice of Privacy Practices:** Please sign and print your name and provide the date below to acknowledge that you have received both layers of this Notice of Privacy Practices. Then return this acknowledgment of receipt to the receptionist or to the address above.

Sign Here _____ **Signature of Patient/Legal Guardian**

Sign Here _____ **Print Name**

_____ **Date**

Sign Here _____ **Signature of Insured or Responsible Party**

Sign Here _____ **Print Name**