Woodcliff Lake Ophthalmology, LLP

2023 UPDATE CONTACT INFORMATION

Name: _____

Address: _____

DOB: _____ **Home:** _____

Cell: _____

Marital Status (circle): Single Married Separated Divorced

Email Address: _____

EMERGENCY CONTACT: _____ **PHONE:** _____

RELATIONSHIP: _____

PREFERRED METHOD OF CONTACT: (CIRCLE ONE) CELL HOME EMAIL

DUE TO NEW HIPPA LAWS, INFORMATION CAN ONLY BE RELEASED TO THE PERSON YOU PUT ON THIS FORM. THE DOCTOR WILL NOT BE ABLE TO RELEASE ANY INFORMATION TO ANYONE ELSE.

My Medical information can be release to: _____

Relationship: _____ Phone: _____

Insurance Name: _____ **Policy #:** _____

Name of the Policy Holder: _____ DOB: _____

Relationship: _____

Pharmacy Name: _____ **Phone:** _____

Pharmacy Address: _____

Primary Care Physician: _____ **Phone:** _____

Patient's Signature: _____ **Date:** _____

6/2023

WOODCLIFF LAKE OPHTHALMOLOGY, LLP
FINANCIAL AGREEMENT

We are committed to providing you with the best possible care. Your clear understanding of our Financial Policy is important to our professional relationship. We participate with Medicare and MOST major insurance plans. We DO NOT participate with Medicaid or with any vision plans.

It is very important that you, the patient, come into our office with all of the required documentation and be fully aware of how your plan works prior to the time of your scheduled appointment. You may be billed for any uncovered services. You, the patient, are the policyholder and it is your responsibility to know your insurance plan.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR. WE WILL ASK TO SCAN YOUR INSURANCE CARD(S) FOR YOUR FILE.

Appointments – 24-hour notice must be provided in the event you cannot keep an appointment. Should you not provide this notice, a cancellation fee of $25 may then be added to your account.

Referrals – If your plan requires a referral from your primary care physician it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral, **you will be required to sign a financial waiver**. It is then your responsibility to provide us with a referral within 48 hours of the date of your visit or you will be personally responsible for that day's services.

Co-Payments – By law we **MUST** collect your carrier designated co-pay. This payment is expected at the time of service. Please be prepared to pay that co-pay at each visit. Should you not pay at the time of service, and we subsequently send you a statement, an administrative fee of $20 may be added to your account.

Our of Network Plans – You will be responsible for any balance your plan indicates as due on their explanation of benefits form. All patients will be responsible for their co-insurance and deductible. If we do not "participate" with your plan, we will send a courtesy bill to that carrier on your behalf. However, should they not pay your claim within 45 days, you will be responsible for the full amount due. Should you receive payment from your insurance carrier, please forward it to our office with the Explanation of Benefit and the Private Insurance Authorization for Assignment of Benefit/Information Release. I, the undersigned, authorize payment of medical benefits to Woodcliff Lake Ophthalmology, LLP for any services furnished. I understand that I am financially responsible for any amount not covered by my contract. I also authorize any holder of medical information about me to release to my insurance company (or their agent) information concerning health care, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating claims of benefits.

Self-Pay Patients – Payment is expected at the time of service unless other financial agreements have been made prior to your visit.

Medicare – We will submit claims to Medicare. The patient will be responsible for the deductible and the 20% co-insurance, which can be billed to a secondary insurance if you have one.

Medicare Lifetime Signature on file: I request that payment of authorized Medicare benefits be made on my behalf to Woodcliff Lake Ophthalmology, LLP for any services furnished to me. I authorize any holder of medical information about me to be released to CMS (and its agents) any information to determine these benefits payable for related services. This information will be used for the purpose of evaluating and administering claims of benefits.

Divorced/Separated Parents of Minor Patients – The parent who consents to the treatment of a minor child is responsible for payment of services rendered. Woodcliff Lake Ophthalmology, LLP will not be involved with separation or divorce disputes.

You are responsible for the timely payment of your account if a balance is unpaid after 30 days, there will be a $10 billing charge added each 3-day billing cycle until the balance is completely paid. Any balance left unpaid for 90 days, without attempts at resolution, will be considered delinquent and may be submitted to a collection agency. If you are having a financial hardship. Please speak with the billing office, and we will make every effort to set up an acceptable payment plan with you. Should it become necessary for us to use an outside agency to collect payment, you will be additionally responsible for whatever charges we may incur. Submission of your account to a collection agency may adversely affect your credit rating.

WE DO NOT PARTICIPATE WITH ANY VISION PLANS
WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, AMERICAN EXPRESS.

Thank you for taking the time to review our policies. Please feel free to ask any questions or share with us special concerns.

Patient's Name: _____

Responsible Party's Signature: _____ Date: _____

Print Name: _____ Relationship: _____

WOODCLIFF LAKE OPHTHALMOLOGY, LLP.

MARY MENDELSOHN, MD, FAAO
Comprehensive Eye Care & Medical Retina
Diabetic Eye Care & Laser Eye Surgery

ALYSON G. YASHAR, MD, FAAO
Comprehensive Eye Care, Cataract Surgery,
Botox, Lid Surgery & Neuro-Ophthalmology

ANNE MARIE ALINO, MD, FAAO
Comprehensive Eye Care, Cataracts,
Glaucoma, Macular Degeneration

NO SHOW, RESCHEDULE & CANCELLATION POLICY

Woodcliff Lake Ophthalmology enforces a formal policy regarding patients that do not show up for their scheduled appointments ("no show"), patients who call to cancel their appointment less than 24 hours prior to their appointment time ("late cancellations") or patients that call to reschedule their appointment less than 24 hours prior to the appointment time ("late rescheduled appointments").

We hereby notify and reserve the right to charge a fee to our patients who are "no shows", "late cancellations" or "late reschedules" with less than a 24 hour notice according to the following fee schedule:

First occurrence:	Patient will be charged a $25.00 fee.
Second occurrence:	Patient will be charged a $35.00 fee.
Third occurrence:	Patient will be charged a $50.00 fee.

__PATIENT MAY BE CHARGED A FULL PRICE OF THE SCHEDULED OFFICE VISIT FOR ANY ADDITIONAL NO SHOW, LATE CANCELLATION OR LATE RESCHEDULED APPOINTMENT AFTER THE THIRD OCCURRENCE__.

If you have any questions pertaining to this policy, please contact our billing office from

Monday – Friday, from 9:00 a.m. to 5:00 p.m. 201-782-1700.

Patient Name DOB

Signature Date Witnessed