Billing Policies & Procedures

I request that payment of authorized (Primary Insurance) _____benefits be made either to me or on my authorized behalf to Dr Caruso for any services furnished to me by Dr Caruso. I authorize any holder of medical information about me to release to the above-mentioned insurance company and its agents. Any information needed to determine these benefits or the benefits payable for related services. I also request that payment of authorized medigap benefits be made to either me or on my behalf to Dr. Caruso for any services furnished to me by Dr. Caruso. I authorize any holder of medical information about me to be released to (Secondary Insurance)_____. Any information needed to determine these benefits payable for related services.
Patient Signature_____Date_____

Payment is due at the time of services if you have no insurance. You will be provided with a receipt upon payment. **Co-payments, deductibles and refractions are due at the time of services! A 10 billing charge will be added if not paid at time of service.**

If you are an emergency visit or out of town emergency and you need a referral, you are required to make all the necessary phone calls to obtain that referral. We do not call or fax other Doctors for these referrals. We will not hold your appointment while you get the referral, you will have to reschedule. All out of town emergencies require a credit card on file.

If your insurance company requires a referral, it is the patient's responsibility to obtain and monitor referrals from your primary care physician. If you have an HMO-no one will be seen for an initial office visit without a referral in our office on the day of your visit. We cannot back bill insurance companies for referrals.

If you are here for a routine visit-you must know who your routine carrier is. If you are not sure, call the number on the back of your insurance card. Upon arrival give the routine insurance information to the receptionist.

You are responsible for all fees that your insurance does not cover. If your bill should go to collections you will be responsible of all legal fees, collections fees, court costs etc... in addition to your original amount owed.
You agree , in order for us to service your account or to collect monies you may owe, Atlantic Eye Center and /or our agents may contact you by telephone at any number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you be sending text messages, emails, using any email addresses you provide to us. We may also contact you by social media.

There is a separate fee for contact lens evaluations and fittings. If you have any questions, please direct them to our billing office. All personal checks will only be accepted with a valid driver's license. Any non-sufficient fund checks will be charged a $20.00 fee.

Please sign upon receipt and understanding of these billing and procedure policies of Atlantic Eye Center and Cape Cataract Center .

Print Name_____ Date of Birth_____ _____

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Social Security Number Date Signature of Responsible Party