Robert M. Scharfman, M.D., F.A.A.O.
3 Hospital Plaza, Suite 310
Old Bridge, NJ 08857

~~ FINANCIAL POLICY ~~

Thank you for choosing us as your eye care provider. We are committed to providing you with the best possible treatment. The following is a statement of our financial policy, which we require you to read and sign prior to any treatment. All patients must complete our patient information and insurance form before being seen.

Full payment is due at time of service. We accept cash, check, Discover, MasterCard and Visa. Appointments canceled with less than 24 hours notice will result in a $25 cancellation fee.

~ Regarding Insurance ~

If we participate with your insurance, all **co-pays** and **deductibles are due at the time of service**. If you are receiving a non-covered service **(i.e. contact lens fitting, contact lens prescription update, laser vision correction, measurement of eyeglass prescription, etc.)** full payment **is required** at the time of service. **There is a $100 charge for the initial contact lens fitting and a $50 charge to update the contact lens prescription each year**. **This fee is in addition to the eye examination**. Note: Some insurance plans deem routine eye exams as a non-covered service. If your insurance plan deems the visit for any testing or measurements done during the visit as a non-covered service, you will be responsible for the charges. **There is a $35 charge for an eyeglass measurement**. **If you do not wish to be measured for eyeglasses, you must let us know.** If your insurance plan requires a referral and you do not have one, you will be responsible for the charges.

For insurance plans in which we do not participate, we may accept assignment of insurance benefits. However, you will be responsible for any balance not paid by the insurance company. Furthermore, if your insurance company has not paid your account in full within 60 days the balance will be transferred to you. Any account with an outstanding patient balance over 90 days will be considered delinquent. Delinquent accounts will be turned over to collection and you will be responsible for all collection and attorney fees or costs in addition to the outstanding balance.

I understand and agree to the Financial Policy:

X _____ _____
Responsible Party's Signature Date

~ Note of Privacy Practices ~

I have received the notice of privacy practices for Robert M. Scharfman, M.D. d.b.a. Atlantic Medical Eye Care.

X _____ _____
Responsible Party's Signature Date

(Revised 10/22/15)