

Freehold Eye & Vision Care LLC
Dr Carolyn LoBocchiaro, OD
FINANCIAL RESPONSIBILITY

Healthy eyes are necessary for good vision. As part of her thorough comprehensive eye exam, Dr. LoBocchiaro concentrates on evaluating eye health. Please be advised, if ocular medical conditions are diagnosed or if there are medical concerns which need to be addressed during the "routine" exam, the patient will be responsible for their medical co-payment and/or deductible even if they are using a vision plan.

A visual field screening and ocular photography are essential components for a complete ocular health assessment.

VISUAL FIELD tests your peripheral vision and neurologic health. It is extremely important for detecting underlying causes for headaches, even if they are only occasional, detecting early glaucoma and monitoring peripheral vision for patients who drive.

OCULAR PHOTOGRAPHY is important for baseline testing and monitoring of the internal and external eye health. It is especially important in aiding the diagnosis of early glaucoma and managing diabetes, hypertension, macula irregularities and ocular freckles. Detecting and monitoring for changes in the future is much more accurate when a photo is available as a baseline for comparison.

For your convenience, Freehold Eye & Vision Care will bill your medical insurance company for these tests even if you are using your vision insurance for your exam. These tests are normally covered in full but on occasion, a co-payment is required, especially if you haven't met your deductible. If that is the case, we will bill you after your insurance claim is processed.

REFRACTION (determination of a spectacle lens prescriptions) most medical insurance companies do not cover this part of your examination, if this information has been determined prior to your visit, **you will be responsible for the Refraction fee of \$60.00 at the time of the visit as well as any insurance specialist copayment.**

CONTACT LENS FITTING (this is a separate service) this is not part of a comprehensive eye exam. Extra testing is involved to properly fit contact lenses and monitor your corneal health even if you are an established contact lens wearer. Additional fees also apply even if you have a vision plan. Payment of this fee is expected on the date of service. **Contact lens fitting fees range from \$100 to \$250 depending on the complexity of the fit and if instruction is required. Rigid contact lens fittings are \$250.**

PRESCRIPTIONS

I consent to having my contact lens/eyeglass prescription released electronically if necessary.

TELEHEALTH SERVICES are offered for your convenience. Billing standards apply. Patient will be responsible for all applicable co-payments and/or deductibles.

I certify that I and/or my dependent(s) have insurance coverage that has been provided directly to Dr. Carolyn LoBocchiaro for all insurance benefits, if any, otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that I am responsible for providing the office with a referral if necessary. I authorize the use of my signature on all insurance submissions. I acknowledge responsibility for accruing interest as well as the fees associated with the collections of my account should it become delinquent. The above-named physician may disclose such information to the insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

I am aware that if the charges are not paid at the time of service, I am subject to a \$25.00 late fee. I am aware that there is a \$20.00 bounced check fee.

Name of Patient _____ Date _____

Signature of Patient/Legal Guardian _____