Diane Hilal-Campo, MD
Eric M. Saunders, MD
43 Yawpo Avenue, Suite #1
Oakland, New Jersey, 07436
(201) 337-9300

I hereby authorize and guarantee payment for all services rendered.

Although fees for services are due and payment expected at the time of services are rendered, if I have been given a grace period for payment of fees, I acknowledge that payment is due and expected at the time the billing statement is received.

In the event that my account becomes delinquent for more than 30 days, I also agree to pay a finance charge of 1.5% per month on any balance due, as well as a reasonable collection cost of $13.25, and/or not to exceed 50% court cost attorney fees and interest fees accrued with collection of this account.

Responsible Party**: Print** _____

Signature: _____ **Date** _____

Full Address: _____

_____

Cell Phone: _____

Home Phone: _____

Email Address: _____

Social Security Number: _____

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Advance Beneficiary Notice (ABN)

NOTE: You need to make a choice about receiving these health care items or services.
We expect that Insurance may not pay for the item(s) or service(s) that are described below. Insurance does not pay for all of your health care costs. Insurance only pays for covered items and services when Insurance rules are met. The fact that Insurance may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Insurance may not pay for some of the following items or services:

Items or Services:	**Reasons Insurance not pay**
· Contact Lens (Evaluations, Fittings & Prescriptions)	· Deductible
· Punctal Plugs	· Not Covered
· Refraction	· No Referral
· Routine Examination/ Complete Eye Exam	
· Some surgeries – Premium Implants	
· Some Testing – OCT's, Visual Fields, Topography, Pachymetry, OPTOS Fundus Photos	

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully. If you have any questions, we would be more than happy to answer them!

Please choose ONE option. Check ONE box. Then Sign & Date Your Choice.
If you do not select Option 1 or Option 2 then Option 1 will be assumed as your choice.

☐ **Option 1.** *Yes, I understand that it will be my responsibility to pay for any items or services that insurance does not pay for.*

I understand that Insurance will not decide whether to pay unless I receive these items or services. Please submit my claim to insurance. I understand that you may bill me for items or services and that I may have to pay the bill while Insurance is making its decision. If insurance does pay, you will refund to me any payments I made to you that are due to me. If insurance denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal insurance's decision.

☐ **Option 2.** *No, I have decided not to receive these items or services.*

I will not receive these items or services. I understand that you will not be able to submit a claim to insurance and that I will not be able to appeal your opinion that insurance will not pay. **I understand that by choosing Option 2, I will NOT be receiving a prescription for glasses or contact lenses.**

_____ _____

Patient's Name

Signature of patient or person acting on patient's behalf

_____

Date

Note: Your health information will be kept confidential. Any information that we collect about on this form will be kept confidential in our offices. If a claim is submitted to insurance, your health information which insurance sees will be kept confidential by insurance.

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Precautions following Dilation

It may be necessary to dilate your eyes during the course of your eye examination or treatment. Dilation results in sensitivity to light and an inability to see well at close range or distance for a few hours. We provide free disposable sunglasses. Patient should wear sunglasses and be cautious walking, going up or down stairs, as well as driving immediately afterwards.

The office will try to do an **Optos** scan to avoid dilation when possible. This will provide the doctor with a scan of the retina to confirm the health of your eye.

Our office fee for Optos is collected at the time of service in addition to any copayment your plan may require. **Our fee for the Optos is $70.00**

Contact Lens Evaluation and Fee

√ If you are having an eye examination and wear contact lenses, our professional staff will be evaluating your current contact lenses to determine their current status. The fee for this service is collected in addition to the fee for an eye examination without contact lenses**.**

Yearly contact evaluations are $100.00 for spherical contacts ($200 FOR NEW WEARERS) and $115 for toric or multifocal contacts ($250 FOR NEW WEARERS).

Refraction Service and Fee

√ A refraction is the process of determining your best corrected vision and if there is a need for corrective eyeglasses or contact lenses. It is an essential part of an eye examination and is necessary to write a prescription for glasses and is a pre-requisite for contact lens fitting.

√ A refraction is **NOT** a covered service by Medicare or most insurance plans. These plans consider refraction a “vision” service, not a “medical” service. Please let us know if you have a separate vision plan.

√ Our office fee for refraction is collected at the time of service in addition to any copayment your plan may require. **Our fee for the refraction is $ 85.00**

I have read and understand the above information. I accept full financial responsibility for the cost of a refraction and/or contact lens evaluation and or/ optos, if provided, and understand payment is due at time of service. I understand that any copayment, coinsurance or deductible I may have are separate from and not included in either the refraction fee or contact lens evaluation fee.

_____	_____	_____
Signature of patient or person acting on patient’s behalf	Patient Initials	Date

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Patient HIPAA Consent

Consent for purposes of treatment, payment and healthcare operations. I consent to use this disclosure of my protected health information by Diane Hilal Campo, M.D. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Diane Hilal Campo, M.D. I understand that diagnosis or treatment by Diane Hilal Campo may be conditioned upon my consent as evidence by my signature on this document. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Diane Hilal Campo, M.D. is not required to agree to the restrictions that I may request. However, if Diane Hilal Campo, M.D. agrees to the restriction it is binding on the practice. I have the right to revoke this consent, in writing, at any time, except to the extent that Diane Hilal Campo, M.D. has taken action in reliance on this consent. My protected health information means health information, including my demographic information, collected from me and created by my physician, another health care provider, health plan, my employer or health care clearing house. This protected health information relates to my past, present or future physical or mental health condition as it identifies me, or there is a response basis to believe the information may identify me. I understand I have the right to review Diane Hila Campo, M.D. Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of the health care operations of Diane Hilal Campo, M.D. Diane Hilal Campo, M.D. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by accessing Diane Hilal Campo, M.D. by calling the office and requesting a revised copy by sent to me in the mail or by asking at the time of my appointment.

Patient Signature _____Date _____

Guardian Signature (If patient is under 18 years old) _____

Access to Private Health Information, I _____ authorize the staff of Diane Hilal Campo, M.D. to release information to the following family members or friends.

_____ Relationship: _____

_____ Relationship: _____

I authorize Dian Hilal Campo, M.D. to contact me concerning health care information through:

__ Home/cell/voicemail # _____ leave a message

__ Work phone/voicemail # _____ leave a message

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Primary Medical Insurance: _____

Secondary Medical Insurance: _____

Vision Plan: VSP EYEMED NVA NO VISION PLAN

Vision Plan Member ID / Primary Holder's Social Security: _____

As the patient/guarantor, I understand it is my responsibility to know my insurance benefits (copayments, coinsurance and deductible amounts) and to provide the office with accurate and current insurance information at the time of every visit. I understand if my insurance is terminated or has changed at the time of service, **I agree that I'm financially responsible at the time of service**.

Does your insurance company require a referral or preauthorization? Yes ____ No___

If so, have you obtained it? Yes ____ No___ (If not, payment is due in full at time of visit.)

I agree to cancel or reschedule my appointment with at least 24 hours' notice, I understand if I don't, I will be charged a $50 "no show" fee. This "no show" fee is not reimbursable by your insurance company. **You will be billed directly for it.**

I've read, understood and agree to the above financial policy for payment of the professional fees. I understand that **I AM ULTIMATLEY RESPONSIBLE FOR ALL FEES AND SERVICES PROVIDED TO ME.**

Signature: _____ Date: _____