Patient Name:_____

EYE DIAGNOSTIC & SURGERY CENTER

Berg, Talansky, Turtel, Pardon, Chiang & Patel M.D.s

BRUCE R. BERG, M.D. LAWRENCE S. TURTEL, M.D.
MARVIN L. TALANSKY, M.D. ILENE B. PARDON, M.D.
PETER K. CHIANG, M.D. AUVNI PATEL, M.D.

Board Certified Ophthalmologists

HEIDI A. SCHULMAN, O.D.

MAIN OFFICE: WANAMASSA
3333 FAIRMONT AVENUE
ASBURY PARK, NEW JERSEY 07712
PHONE (732) 988-4000 FAX (732) 988-9502
BUSINESS OFFICE (732) 988-4949
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525 ROUTE 70, BRICKTOWN, NJ 08723
PHONE (732) 477-2500
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200 WHITE ROAD, SUITE 201, LITTLE SILVER, NJ 07701
PHONE (732) 530-8500

ASSIGNMENT OF BENEFITS / AUTHORIZATION TO RELEASE INFORMATION

Financial Responsibility:

I have requested medical services from Eye Diagnostic and Surgery Center on behalf of myself and/or my dependents. I understand and agree that I am responsible for the following expenses: any service my insurance carrier deems "non-covered", all coinsurance and/or copayment amounts, all deductibles, any amount that exceeds benefit limits under my insurance plan, and any amount my insurance plan deems not covered because I was not insured on the date of service.
In the event that my account is not paid in a timely manner, it may be turned over to a collection agency for further action. I acknowledge that I may be liable for any and all charges associated with collecting my outstanding balance. This may include collection agency fees and/or court costs.

Assignment of Benefits:

I hereby authorize and direct my insurance carrier(s) including, Medicare, private insurance and any other health/medical plan to issue payment directly to the Eye Diagnostic and Surgery Center for services rendered to me and/or my dependent. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information:

I hereby authorize Eye Diagnostic and Surgery Center to: (1) release any information necessary to insurance carriers regarding services rendered and my medical treatments and (2) process insurance claims generated in the course of examination or treatment. I certify that the information I have reported with regard to my health insurance is correct. If my insurance changes I will promptly notify Eye Diagnostic and Surgery Center. A photocopy of this assignment is to be considered as valid as the original.

Patient/ Responsible Party Signature Date

Patient Name:_____

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ROUTINE EXAMS

Routine vision exams are not covered by many medical insurance contracts. Insurance companies have determined that nearsightedness, farsightedness, astigmatism, blurry vision and some other conditions that are correctable by glasses and/or contact lenses and the screening for such conditions (*called* refraction) are not considered "medical" problems and are therefore considered "routine" and are not eligible for reimbursement. If your insurance company does not provide for "routine" vision examinations, you are responsible for payment at the time of your visit. If you are unsure of your insurance coverage, please contact your insurance company for clarification.

If we submit charges to your insurance company and they determine at a later date that the charges are not covered under your contract, you will be responsible for payment.

Please sign below to indicate that you understand and agree to these terms. Our staff is available to answer any questions you might have.

_____ _____

Signature of patient or parent/guardian if patient is a minor Date:

ATTENTION MEDICAID PATIENTS:

We are NOT MEDICAID participating providers and have the right not to accept you as a patient. If you choose to come to our practice and you have commercial insurance primary (ex: Blue Cross Blue Shield, Aetna, United Healthcare) and Medicaid secondary, you will be financially responsible for the patient portion of the charges. This applies to patients over the age of 18. Your signature acts as your acknowledgement and agreement of this responsibility.

_____ _____

Patient/Responsible Party Signature Date