Dr. Adriana Wiseman, O.D, P.C

Mobile Eye Care

FINANCIAL AGREEMENT

~Payment upon service:
Accepted cash, checks, debit, credits cards.

~ Insurance:
If we participate with your insurance plan, you are responsible for any copay or non-covered charges or percent of non-covered charges. You authorize this office to act as your agent to obtain payment for claims of insurance benefits. Any unpaid or denied claims remain your responsibility.

~ Non-covered fees:
Dr Adriana G Wiseman dba New Vision Optometry reserves the right to charge travel fees as discussed prior or at the time of service. I acknowledge and accept responsibility for travel fees.

Balances remaining after payment is due may incur 1% monthly interest, up to 12% yearly.

There will be a $25.00 fee for returned checks.

~ Consent:

I authorize this office, Dr Adriana G Wiseman OD PC, to act as my agent to obtain payment of my insurance benefits. I request that payment of authorized insurance benefits of all my insurance carriers, including primary and secondary insurances, be made to me or in my behalf to Dr Adriana G Wiseman, ODPC dba New Vision Optometry for any services or materials furnished to me by this office. I authorize any holder of medical information about me to release to the CMS and its agents any information needed to determine these benefits payable for related services. If I have other health insurances (as in item 9 of form CMS1500 or its electronic format) my signature authorizes release of the above medical information to the insurer or agency shown and authorizes this office, Dr Adriana G Wiseman, ODPC dba New Vision Optometry, to act as my agent as above.
I have been advised that based on Medicare part B, some services may be denied as not medically necessary. Therefore, I acknowledge and accept responsibility for payment of these services such as CPT 92015, refraction.

I certify that I am the patient or duly authorized person to release and receive insurance and medical information. In the event that my insurance should not pay for the products or services provided by Dr Adriana G Wiseman ODPC , I agree to be responsible for all charges. I have read the information in this financial form and agree to the terms listed.

PRINT NAME _____

SIGNATURE _____

DATE _____

Tel 240-203-9333 Fax 240-319-7376 Email Desk@NewVisionOptometry.com