NIGHTINGALE
EYE ASSOCIATES

211 Central Park West Suite 1E
New York, NY 10024
T: 212-877-7138
F: 212-877-3912
www.nightingale-eyes.com

Andrew B. Nightingale, MD • Jeffrey D. Nightingale, MD

Payment Policy

- Our office participates with most insurance companies but each plan may vary by employer and insured. ***PLEASE KNOW YOUR PLAN***. Co-payments are due and payable at the time of your office visit. Deductible and / or other balances that are your responsibility will be billed to you once these amounts are determined.
- If you are a member of an **HMO**, you are required by your plan to obtain a referral prior to your visit with us. If your plan requires a referral and you have not obtained one, your examination may need to be rescheduled.

I authorize the release of information to determine eligibility for payment and / or to obtain reimbursement. I understand that if my account is not paid directly, I am responsible for the full amount and may be charges all costs associated with collections of the amount due. I authorize the release of any medical information necessary to process claims and the release of payment to Dr. Jeffrey D. Nightingale and / or Dr. Andrew B. Nightingale.

AGREEMENT OF RESPONSIBILITY

I understand the professional services are rendered to the patient and the patient is responsible for the charges incurred. I understand I am financially responsible for the charges not covered by my insurance company. I understand the provider does not accept responsibility for collecting my insurance claims or for negotiating a settlement on disputed claims. I have received and reviewed the payment policy and agree to the conditions set forth in such policy. I understand I will receive a monthly statement for any balance due by me.

Initial: _____

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES

I acknowledge that I have read the Notice of Privacy Practices.

Initial: _____

RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS

I authorize the use of this form on all my insurance submissions and authorize release of information needed to process a claim to my insurance company. I permit a copy of this authorization to be used in place of an original. I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered.

Initial: _____

Print Name _____

Signature _____ Date: _____