Vincent R. Vicci Jr., O.D., D.P.N.A.P.

Nathalia C. Broderick, O.D.

Binocular Vision & Perception
Vision Rehabilitation
General Vision Services

592 Springfield Avenue
Westfield, NJ 07090
Office (908) 654-7950
Fax (908) 654-7956

Financial Policy

Thank you for entrusting your care with the office of Dr. Vicci and Dr. Broderick. The following information is provided to all patients for their understanding of the financial policy.
Please read carefully and if you have any questions or concerns, the staff will gladly assist with answers.

Dr. Vicci and Dr. Broderick participate with Medicare traditional A – B ONLY

WE DO NOT participate with **Medicare HMO or Medicaid**

Cancellation/No Show Fee

In order to provide effective and efficient care, we have an appointment cancellation policy that applies to new and existing patients. Please note that no shows and late cancellations do affect other patients in need of our care. In order to minimize these issues, we have the following policy.

We request that you give the office at least **24 hour notice either by phone or email** if you need to cancel or reschedule. If you miss an appointment and do not provide at least 24 hour prior notice, we will consider this a missed appointment and you will be charged a **$100.00 fee. This fee must be paid prior to rescheduling future appointments.** We go to great lengths to accommodate patients from our waiting list, please give us the courtesy of the 24 hour notice so we may then assist other patients. Thank you for your understanding.

Medicare

The office will submit for Medicare patients which usually pays 80%. It will then be submitted to the secondary carrier. Remaining balance will be billed to the patient. In addition, patients are responsible for the **refraction fee of $50. This is part of the exam that Medicare or your Secondary Insurance does not cover.** This is on an annual basis. Any balance remaining will be billed to patients through our billing company **R&S Electronic Medical Billing**

We suggest that patients contact their insurance companies and inquire about out of network benefits. We will provide you with a receipt which includes medical and diagnostic codes for you to be reimbursed.

Glasses:

We do not participate with vision plans. We request a **deposit on the frame** and the balance to be **paid in full** when the glasses are completed. We appreciate all prescription glasses to be picked up within 2 weeks.

PRISMS :

The use of prism glasses are prescribed as part of the therapeutic treatment for some patients. There is a charge of $95.00 for a "press on prism" which is completed in office. This is a non-refundable charge.

Letters/Reports:

If you request a supplemental report or an addendum there will be an additional fee. The amount will be dependent on the extent and will be discussed at the time of the request.

Contact Lenses Fitting:

Contact lenses must be **paid in full** when ordering. They can be shipped directly to your home if desired or picked up in office. With regard to the appointment for fitting, the cost is 350.00 and this includes the initial visit as well as two follow ups.

By signing this you acknowledge and agree to the financial policy of

Dr. Vincent R. Vicci Jr., O.D., D.P.N.A.P. F.N.O.R.A.
Dr. Nathalia C. Broderick, O.D.

Patient's Name _____

Signature _____ Date _____

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In compliance with the Health Insurance Portability and Accountability Act (HIPAA), we have thoroughly reviewed our policies as they apply to HIPAA.

The HIPAA Privacy Rule does provide for the use and disclosure of protected health information without patient authorization for permissible reasons. We want to assure you that our policies have been carefully designed to protect our patient information.

We understand that the new HIPAA regulations are just one facet of the relationship between the doctor and his patients, and the success of our practice. Our commitment to our patients and our patients' privacy ensures that we will be in compliance with all government regulations.

Please sign below. This copy will remain in your patient file.

Name:_____ Date:_____

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Patient Consent Form

Our notice of Privacy Practices provides information about how we use and disclose protected health information about you. The Notice contains a Patient Rights sections describing your rights under the law.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor this agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care options. Our practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- Patient has the right to access, inspect, copy, and amend his/her own records.
- Patient has the right to receive and accounting for disclosures of information.
- Our practice may allow your health care insurance plan access to your protected health information if the insurance plan requires it to pay the practice for the service we provided to you.
- Our practice may disclose protected health information to any health care provider who has referred you to us for treatment.
- Our practice is a covered entity that is required by law to safeguard patient information in accordance with the law.
- Our practice contacts patients for appointment reminders notice of health services and for billing questions regarding patients' account.
- Our practice has the right to change the Notice of Privacy Policies.

Name:_____ Date:_____