OFFICE POLICIES AND FINANCIAL ARRANGEMENTS

- Co-payments, co-insurance, deductibles, all previous balances, non-covered services and/or amount exceeding your annual maximum are due at the time of service.
- If your insurance requires you to have a referral at the time of the visit, it is your responsibility to obtain the referral. If you do not have one at the time of service, you are required to pay for the visit in full.
- Returned checks are subject to a **$40.00 FEE**.
- Routine eye examinations, refractions, contact lens fittings, contact lens evaluations and vision therapy are **NOT COVERED** by most insurance companies.
- There is a **$30.00 CANCELLATION FEE** for failure to cancel within **24 hours** prior to your appointment. Except for visual evaluations and/or perceptual appointments, there is a **$75.00 CANCELLATION FEE** for failure to cancel these appointments within **48 hours** prior to your appointment.
- Visual Skills Evaluations and Visual Perceptual Evaluations are **NOT** covered by any insurance plans/companies.

AUTHORIZATION FOR ASSIGNMENT OF BENEFIT

I HEREBY AUTHORIZE DRS/ ANDREA THAU, FRAN REINSTEIN, MARILYN VRICELLA, ERICA SCHULMAN AND/OR MATTHEW VAUGHN TO APPLY FOR BENEFITS ON MY BEHALF FOR COVERED SERVICES RENDERED BY THEM. I REQUEST THAT PAYMENT FROM MY INSURANCE COMPANY BE MADE DIRECTLY TO DRS. ANDREA THAU, FRAN REINSTEIN, MARILYN VRICELLA, ERICA SCHULMAN AND/OR MATTHEW VAUGHN. I CERTIFY THAT THE INFORMATION I HAVE REPORTED WITH REGARDS TO MY INSURANCE COVERAGE IS CORRECT. I ACKNOWLEDGE THAT I AM RESPONSIBLE FOR THE PAYMENT OF THE ENTIRE BILL IF MY INSURANCE COMPANY DOES NOT COVER ANY SERVICES RENDERED.

PLEASE BE SURE YOU HAVE READ THIS DOCUMENT VERY CAREFULLY.

I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.

SIGNATURE______________________________ DATE____________________

ACKNOWLEDGMENT OF HIPAA RECEIPT

I acknowledge that I received and/or reviewed a copy of Dr. Andrea P. Thau and Associate's Notice of Privacy Practices.

I further consent to the release of my health information for purposes of treatment, payment and health care operations and as authorized by law under the circumstances described in the Notice of Privacy Practices.

Patient name: ____

Signature: ____

If you are signing as a personal representative for the patient, describe your relationship to the patient and the source of your authority to sign the form:

Relationship to Patient: ________________________ Print name: _______________

Source of Authority: ______________________________