Financial and Privacy Policy

Broadway Eye Clinic Insurance Policy

There are two types of health insurance that will help pay for your eye care services. You may have both types and we accept most insurance plans in both categories:

- Vision plans (such as VSP, EyeMed, Spectera and others)
- Medical plans (such as Blue Cross/Blue Shield, Medicare and others)

Vision plans only cover routine vision wellness exams and sometimes eyeglasses and contact lenses. Vision plans do not cover medical eye care (the diagnosis and treatment of ocular surface disease, glaucoma, macular degeneration, cataract, etc).

If you have both types of insurance plans it may be necessary for us to bill some services to one plan and some services to the other. We can only bill your vision and/or medical insurance for services if we are a participating provider for that company. In the event that we do not take your major vision or medical insurance, we will provide you with an itemized receipt so you may file for reimbursement with your insurance provider.

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- I understand all charges and co-pays are due at the time of service by cash, check or credit card. Broadway Eye Clinic will bill my vision or health insurance for services that are authorized. If the services billed to my insurance are denied, I am responsible to pay any balance upon receipt of the bill within 90 days.
- I acknowledge and agree that an interest rate of 1.5% per month (18% annum) will be charged on all balances that remain unpaid 90 days after the date of service. In the event of default and referral to an attorney or collection agency, I agree to pay all collection costs, including reasonable attorney fees.
- I understand Medicare and other health or vision insurances will only pay for services they are obligated to provide under law or contract. If insurance denies payment for reasonable services allowed by law, I understand I am liable for payment of that service.
- I agree to provide Broadway Eye Clinic with my insurance card so they may copy it for insurance billing information. I understand if I do not provide an accurate insurance card, they may be unable to bill my insurance.
- I consent for Broadway Eye Clinic to use or disclose my health information for treatment, payment and healthcare operations. I have had the opportunity to review the Broadway Eye Clinic Privacy Practices consistent with United States law and acknowledge that I have been offered a copy of these Privacy Practices.
- I understand I am entitled to a copy of my glasses and contact lens prescription. I acknowledge that I will be provided with a copy of my contact lens prescription at the completion of my contact lens fitting. I authorize Broadway Eye Clinic to maintain these prescriptions in my medical record and understand that I may request a copy at any time.

Patient (or Parent if under 18) E-Signature
(draw, upload or type) (ESign)

Date :