Northern New Jersey Eye Institute, P.A.
Lifetime Signature Agreement
(Must be completed prior to exam)

- I consent to treatment for this patient

  I hereby authorize my insurer to assign and transfer any and all applicable plan or policy benefits and rights to Northern NJ Eye Institute and any appointed business associates working with them for the sole purpose of making sure all protected rights and benefits under my plan are administered accurately, including the right to all remedies, disclosures, rights of appeal, administrative reviews and litigation on my behalf. This authorization includes any and all other rights permissible under state and federal laws. I understand under all applicable state and/or federal regulatory guidelines that I, having the right and authority, designate payment to be made and mailed directly to the provider listed for all services rendered.

- I authorize any holder of medical information and medical records about me to be released to the Healthcare Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I, further, authorize the release of medical information for the purposes of treatment, payment or healthcare operations.

- I understand and agree to pay any or all co-payments and deductibles at time of service, or I may be responsible for a $20.00 service charge. I understand that there may be a service charge of 1.5% per month for any unpaid balance more than thirty days past due. I also agree to pay all responsible attorney fees and collection costs in the event of default of payment of my charges.

- I understand that all fees and services are due payable at the time services are rendered if the Northern New Jersey Eye Institute does not participate in my insurance plan, unless written arrangements are made.

- I understand that I am responsible to bring any necessary referrals at the time of service, or I may be liable for all charges.

- Cancellation policy for visits and procedures including minor surgery: I understand that there may be a charge of $25 for any visit or procedure that is not cancelled with 24 hours advance notice.

- Cancellation policy for surgical visits: I understand that there may be a charge of $200 for any surgical appointment not cancelled with 48 hours advance notice.

- I understand that if I am billed Medicare's reduced rate and it is determined that I am not Medicare eligible; I will be billed at the Institute's standard rate.

- I understand that I am responsible for any services that are not covered by my insurance company.

- Further, I understand that I am entering into a contractual relationship with the medical practice/physician for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care, and may have result in irreparable harm to a medical provider. As additional consideration for my professional care provided to me by medical practice/physician, I (the patient) and/or my representative agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical malpractice against medical practice/physician.

- Furthermore, should a meritorious medical malpractice care of cause of action be initiated or pursued, I (the patient) and/or my representative agree to use ABMS board-certified expert medical witness(es) in the same or similar specialty as (physician). Furthermore, I agree that these expert witnesses will adhere(s) to the guidelines and/or code of conduct defined by the specialty society(ies) for expert witnesses in the area(s) of medicine that would typically have the background and experience to opine on such a case

- I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

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Signature of Patient, Parent or Legal Guardian Date