Four County
Family Eyecare

Dr. Michael S. Cohen, Optometric Physician
225 North Route 73, Berlin NJ 08009-9751
Phone (856) 767-9101 Fax (856) 767-9131

FINANCIAL POLICY

1. All fees are due the day services are rendered or materials are ordered.
2. We accept the following forms of payment: cash, check, Master Card,Visa, Discover, American Express.
3. The patient who seeks care is responsible for the payment of all fees.
4. The person bringing a child into the office is responsible for the payment of all fees.
5. When we are not a provider for a third party insurance, the patient who seeks care is responsible for the payment of all fees. We will provide a billing slip that can be submitted to an insurance company.
6. When we are a provider for a third party insurance, any deductibles, co-payment or patient responsible fees are due when services are rendered or materials are ordered.
7. It is the patient's responsibility to bring to our office his/her insurance cards and insurance information. Without an insurance card, payment responsibility is yours at the time of the office visit.
8. Payment must be made in full before eye wear or contact lenses may be ordered.
9. If an attorney's services are required or if it is necessary to resort to small claims court, the patients will be required to pay the attorney's fees and costs of court in addition to paying the amount due or ordered by the court.

For patients with third party plans:

I authorize my third party plan to pay Dr. Michael S. Cohen directly. If this is not permitted by my policy, then send the check made out to me at the following address.

Accounts Receivable
Four County Family Eye Care Center
Dr. Michael S. Cohen
225 North Route 73
Berlin NJ 08009-9751

I authorize Dr. Michael S. Cohen to file complaints in my behalf if my third party carrier does not properly handle my claim.

In order to ensure payment of my claim, I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

_____ _____

Patient Name Date

_____

Signature of Parent, Parent/Guardian