ROBERT J. FUCIGNA M.D.
Office: (203) 348-7575
Fax: (203) 348-2893
DoctorFucigna@AOCT.co

ADVANCED OPHTHALMOLOGY of Connecticut

1455 EAST PUTNAM AVE
Old Greenwich, CT 06870
www.AOCT.co

Insurance / Managed Care Billing Waiver

Below is an outline of our managed care policies. We hope that clear communication will help alleviate some of the inconsistencies and incongruous policies the managed care companies have placed on their members. **Advanced Ophthalmology of Connecticut** will make every effort to collect from your insurance plan. With all of the varieties of coverage available, it would be impossible for this office to know each plan or inquire for each patient.

Insurance & HMOs

Payment is required at the time of service for the following:

- All co-pay amounts, deductibles that have not been met & co-insurances.
- Refraction (**$69.00**) **NOT** covered by Medicare or most insurance plans.
- All new contact lens fittings (**$250.00**) & contact lens updates (**$95.00-$105.00**).

You will be billed for the following:

- Fees for services that were denied due to failure to obtain a referral. It is your responsibility to abide by your insurance company's rules.
- Any services denied by your plan that is billable within the guidelines of the insurance plan.

I agree to pay for the services rendered by my physician at **Advanced Ophthalmology of Connecticut**. I authorize you to release any information to my insurance company for the purpose of processing claims including medical information.

Signature: _____ Date: _____
Patient or Legal Guardian

Print Name: _____

Medicare Waiver (sign ONLY if Medicare/Medicare HMO is your insurance provider)

I understand that **Medicare** considers a routine exam and refraction as a "Non-Covered" procedure. I understand that I am responsible for payment in full for these procedures at today's visit. If you have enrolled in a Medicare HMO, it is your responsibility to inform the staff and remit your Co-pay and Deductibles at the time of service. I authorize **Advanced Ophthalmology of Connecticut** to release any information to Medicare for the purpose of processing claims; this included any medical Information.

Signature: _____ Date: _____
Patient or Legal Guardian

Print Name: _____

HIPAA Acknowledgment:

I acknowledge that I may be provided with a copy of Advanced Ophthalmology of Connecticut HIPAA privacy notice

Signature: _____ Date: _____
Patient or Legal Guardian

Print Name: _____