❑ **FRAMINGHAM OPTICAL**
44 Union Ave., Framingham, MA 01702
P: 508.875.9636 F:508.875.3770

❑ **COMFORT VISION**
543 Washington St., Quincy MA 02169
P: 617.657.0205 F:617.657.0206

❑ **QUINCY SHORE EYE CARE**
60-A Quincy Shore Dr., Quincy MA 02171
P: 617.302.3644 F:617.302.4245

❑ **LILLY EYE CARE**
328 Washington St., #3, Wellesley MA 02481
P:781.235.6273 F:781.235.7645

REGARDING YOUR INSURANCE

As Doctors of Optometry, we are pleased to be providers for many insurance plans. We participate in these plans for several reasons but the most important one is because it allows you, the patient, and the opportunity to have an optometrist who has met or exceeded the stringent requirements that many of the insurance companies require of their doctors.

Because of the incredible number of insurance companies and the diversity of their plans, we call to insure eligibility of benefits of our patients. This enables the patient to pay the appropriate fees. However, there are unfortunately many instances when, for whatever reasons, insurance claims are not paid to the doctor. Often time, it is because the patient had a similar claim within the allowed time interval between visits. Other time, it is for reasons that involve disputes between patients and their insurance companies. Regardless of the reason, the patient is responsible for full payment of the bill. Once services are rendered, it is the sole responsibility of the patient to ensure that the fees are paid for, even if the insurance company gave approval for the visit and later rejected the claim.
It is unfortunate when these events occur and we try our very best to guarantee coverage for you. However, it is important for you to understand your responsibilities as a patient and as an insured participant of a specific insurance plan.

I understand that I am ultimately responsible for the fees generated at my visit today with the Doctor of Optometry.

X _____ DATE: _____

INSURANCE INFORMATION

Insurance Company: _____

Primary card holder: _____

Relation to primary card holder: _____

Date of birth of primary card holder: _____

Employer of primary card holder: _____

Address of primary card holder (if different from patients): _____

_____

HIPAA COMPLIANCE ACKNOWLEDGEMENT OF INFORMATION RECEIPT

I acknowledge that I have read and/or was given a copy of the Notice of Privacy Practices

Date: _____

Patient/Guardian Name: _____

Signature: **X** _____