I. David Nestorowicz, O.D. L.L.C.
Optometric Physician
Family Eye care
Lic.#OA00607300/Cert.#TO00144500

Pond Road Plaza
4345 Route 9 North
Freehold, NJ 07728

Phone: (732) 431-1004
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Authorization and Release

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners.
I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me.
I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.
We often have patients that have both vision and medical insurance. They are very different in terms of the services they cover and it's important for our patients to understand those differences. Vision coverage is mainly designed to determine a prescription for glasses and is not equipped to deal with complex medical conditions and/or diagnoses and does not include a detailed examination of the retina. When a medical diagnosis or condition is present, such as high blood pressure, diabetes or eye disease, it is necessary to file the visit with your major medical carrier and the co-pays for that insurance carrier themselves. There is no way to know prior to the examination which type of insurance our office will be able to file for you. We make every effort to be on every major carrier for your convenience and we file those claims for you. In the event that we do not take your major medical/vision insurance, we will provide you with an itemized receipt so that you may file with your carrier for reimbursement. If you have any questions, please let us know.

Financial Arrangements

For your convenience, we offer the following methods of payment. Payment in full is required for your visit. _Cash _Visa _MC _Discover _Amex

Late Charges

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional services except for emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

Signature____ Date_______________