Non Covered Services

Dear Patient:

In general, medical insurance (that pays for your visits to your family doctor) will cover the majority of your eye examination, such as glaucoma tests, retinal evaluations, and other ocular health assessments. Not usually covered are *vision* services. Listed below are some of the more common items not typically covered by major medical plans.

Refraction
This determines your eye glasses prescription and most medical insurance plans do not pay for the refraction component of your eye exam. This is considered a *vision* procedure. *Vision* insurance plans usually do cover this service (such as VSP, MESC, EyeMed, Spectera, HMO's, etc.). If not covered by your medical insurance the cost of the refraction is **$40.00.**

Contact Lens Service
A fitting, renewal or evaluation for contact lenses will be performed for all patients requesting a contact lens prescription. Most medical insurance plans do not pay for contact lens services. The service **cost varies** with the type of contact lens, your experience, etc., and will be discussed with you prior to your services. *Vision* insurance plans usually do cover this service.

Office Policies

Co-Payment and Deductibles
Co-Payments, deductibles and non-covered service fees are due at the time of service.

No Show Fee
If an appointment is not canceled (or rescheduled) within 24 hours of the actual appointment our office charges a $20 no show fee. This is not covered by insurance.

Please feel free to ask any questions you may have. Any services that are not covered by your insurance will be explained to you before they are done.

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

_____ _____

Patient/Guardian Signature Date

Assignment And Release

I, the undersigned, assign directly to Dr. John Fagan all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that benefits quoted to me are not a guarantee of payment by my insurance company, and that final determination can only be made when the claim is processed. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature_____ Date _____

Print Name _____ Relationship to Patient _____

Notice of Privacy Practices

By signing this form I am acknowledging that I have received the Notice of Privacy Practices from Dr. John E. Fagan.

_____ _____

Please Print Name Relationship to Patient

_____ _____

Signature Date