

EAGLE VIEW OPTOMETRY

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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 eyeglasses 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 cover this service (such as VSP, EyeMed, Superior, KF 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. *Vision* insurance plans usually do not cover both the comprehensive exam and a contact lens exam. The service **cost varies** with the type of contact lens, your experience, etc., and will be discussed with you prior to your services.

Prescription Copy

At the time of service, or finalization of refraction, you will receive a copy of your updated prescription. Whether that may be for eyeglasses, contact lenses, or both. In the possibility of your prescription being lost or misplaced we are able to provide you with another copy electronically (i.e. Email, fax). By providing your email and initialing below you are giving your permission to receive another requested copy electronically from our office.

Email for electronic correspondence: _____ Initials: _____

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 services not covered by my insurance.

Responsible Party Signature

Date

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Assignment and Release

I, the undersigned, assign directly to Dr. Brian Foutch or 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 _____ Relationship to Patient (If Minor)

Print Name _____ Date

Notice of Privacy Practices

By signing this form I am acknowledging that I have been given a copy to read or have received a personal copy of the Notice of Privacy Practices from Eagle View Optometry.

Please Print Name Relationship to Patient (If Minor)

Responsible Party signature Date