Eagle Family Vision
eye care & wear

FINANCIAL POLICY

It is our policy to accept and file insurance for our patients, when applicable. If you are covered under an HMO or PPO policy, *it is your responsibility* to notify our office that you are covered on a certain plan. You must present your card and/or referral to our staff **before services are rendered.** *All deductibles and co-pays will be collected at the time of service.* **Each insurance coverage is verified, however, the amount you are asked to pay is only an ESTIMATE, THERE MAY BE A BALANCE DUE after your insurance company makes payment.** You are responsible for any balance that your insurance company does not pay. If your insurance cannot be verified or you do not have your insurance card, you will be responsible for **payment in full** at the time of service. There will be a $25 fee for any returned check.

REFRACTION POLICY

During your visit, a refraction may be performed to determine your need for glasses or to evaluate if any further visual improvement can be achieved. Most of the time, this is a necessary and essential portion of your eye exam. Please be aware that this is a **non-covered** service by Medicare and most other medical insurance companies. When your insurance does not cover the refraction, the patient is responsible for the fee. Our office currently charges $35 for this procedure. We appreciate your cooperation in collecting this fee at the time of service.

I authorize all insurance benefits to be paid directly to Eagle Family Vision, and agree to be financially responsible for any remaining balance (deductible, co-insurance, refractions, eyeglasses, contact lenses or any balance) not paid by the insurance.

CONSENT TO RELEASE INFORMATION

By signing this form, I authorize Eagle Family Vision to release information regarding myself and my medical treatment to insurance companies, surgery centers and physicians as deemed necessary for treatment. I also consent that Eagle Family Vision may call/text/email my house or other designated locations and leave a message on voicemail or in person in reference to appointment reminders and insurance items. In addition, the office may mail to my home appointment reminders and patient statements.

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

By signing below, I am acknowledging that I have been provided with a copy of Eagle Family Vision Notice of Privacy Practices, which explains how my medical information will be used and disclosed.

I have read, understand, and accept the above policies.

Print Name _____ **Date** _____
Signature _____ **Relationship to pt** _____

ABOUT YOUR INSURANCE

There are two types of health insurance that will help pay for your eye care services and optical products. You may have both types and Eagle Family Vision accepts most insurance plans in both categories: 1) **Vision plans** (such as VSP, Eyemed and others) and 2) **Medical insurance** (such as Aetna, BCBS, Medicare and others).

**Vision plans only cover routine vision wellness exams, along with eyeglasses and contact lenses. Vision plans do not cover medical eye care (the diagnosis, management or treatment of eye health problems).

**Medical insurance must be used for medical eye care.

If you have both types of insurance plans, it may be necessary for us to bill some services to one plan and some services to the other. We will follow a procedure called coordination of benefits to do this properly and minimize your out-of-pocket expense.

If some fees are not paid by your insurance, we will bill you for them, such as deductibles, co-pays, and non-covered services as allowed by the insurance contract.

Unless otherwise specified, our office does not participate in discount only vision plans.

Please provide your insurance cards to our office so we can scan them into our system. We need to have your medical insurance card or Medicare/Medicare replacement card on file in case we should need it in the future for billing purposes.

CONTACT LENS FITTINGS/EVALUATIONS

There is a fee in addition to the exam charges to fit and/or evaluate contact lenses. This covers four weeks of follow-up visits, trial lenses, starting solutions and the instruction of care/wear of your lenses, if needed. This charge is necessary at every yearly exam (and periodically in between) in order to ensure safe contact lens wear and continued good corneal health. If you have previously worn contacts, bring any information you have about the type of lenses you wear on the day of your appointment. Contact lens fitting/evaluation fees may be covered by some insurance companies, but will the responsibility of the patient, if not. These fees are non-refundable.

I have read and accept these policies.

Initials: _____