# FINANCIAL DISCLOSURE AND AGREEMENT FORM

**INSURANCE**

It is our policy that all fees be paid at time of service. As a courtesy to our patients, we will complete and file insurance forms related to services provided for any insurance company that we participate with. Please be aware that *not all* services are covered by insurance and non-covered fees are the responsibility of the patient. Your contract is between you and your insurance carrier. It is not our responsibility to contact your insurance company with regard to payment or nonpayment of your bill. We will allow six (6) weeks for payment of fees submitted to your insurance company, at which time payment will become your responsibility. Should your insurance carrier send payment directly to you, we expect you to deposit the check into your account and reissue us payment promptly to our office.

**Initials: ___________**

A visit will be billed as a medical eye examination whenever a patient is being evaluated, followed, or treated for a medical condition or symptom. The condition or symptoms can be elicited by the patient during evaluation of the patient's history or found during the examination by the doctor. Examples that necessitate billing to medical insurance include but are not limited to:

*Diabetes, Dry Eye, Glaucoma, Glaucoma Suspect, Narrow Angles, Choroidal Nevus, Macular Degeneration, Vitreous Floater, Cataracts, Eye Irritation, Eye Itching, Contact Lens Intolerance, Lattice Degeneration, Amblyopia (Lazy Eye), High Myopia.*

These visits are not billed to a routine vision care plan, such as Vision Service Plan or EyeMed. However, we will attempt to do a coordination of care between insurances when applicable.

**Initials: ___________**

**COLLECTIONS**

Should it be necessary to turn my account to a collection agency, I agree to pay all collection fees, court costs, and reasonable attorney's fees in addition to the balance due. A $50 charge will be assessed to your account if it is turned over to collections.

**Initials: ___________**

**MEDICARE / MEDICAL INSURANCE / REFRACTION FEES**

If I have Medicare Part B or many other types of Medical Insurance, I understand and acknowledge that refraction services are often not covered. I understand that I am responsible for the refraction costs of $55. This fee is due on the date of service.

**Initials: ___________**

**CONTACT LENS EXAMINATION FEES**

There is a yearly contact lens evaluation fee for all contact lens wearers that many insurance companies will not pay for. Fees for first time contact lens wearers (including subsequent teaching visits) range from $145 - $250, depending on type of lenses. Annual contact lens evaluation fees range from $85 - $125 thereafter. Payment for contact lens evaluation is due on date of service.

**Initials: ___________**

**60-DAY PRESCRIPTION GUARANTEE**

There are many factors that can affect your visual acuity. Our doctor honors a guarantee on your prescription within 60 days of your initial examination. Fees are separate for your comprehensive exam for glasses (refraction), contact lens evaluations, and contact lens materials. The contact lens evaluation includes the initial contact lens evaluation and progress visits within the initial 60 days. Additional visits after 60 days from the evaluation date will be subject to our usual and customary fee of $55 per visit. These additional visits are not covered by insurance. Prescription problems with new glasses/lenses need to be addressed within 60 days of initial exam. Any visits required for checking prescriptions after this 60 day period are also subject to the $55 fee per visit for additional refractions.

**Initials: ___________**

Signing this form indicates that you have read and accept all of the fees and conditions set forth above. Your signature on this form will serve and be kept as your "Signature on file."

| ______________________________ | ______________________________ | ________________ |
|---|---|---|
| **Patient Name** | **Patient or Parent Signature** | **Date** |