

Insurance Fees, Policies, and Verification

Insurance information is required at the time services are performed. Primary Eyecare Associates requests both medical and vision insurance information to be kept on file in the event that a service can be billed to your medical insurance that may not be covered under routine vision plans. Primary Eyecare Associates will communicate with you before claims are sent to medical insurance.

Primary Eyecare Associates does not coordinate benefits between your insurance carriers unless this has been approved with prior authorization. Primary Eyecare Associates will NOT accept or process insurance benefits if they are discovered after services have been rendered.

Vision Insurance:

(Ex. Eyemed, VSP, Davis Vision, Spectera)

Routine eye exams with refractions are typically covered with a copay. They may provide material (frame, lens, and/or contact lens) benefits or an allowance to use towards materials.

Medical Insurance:

(Ex. Aetna, Cigna, Medicare, Tricare, UnitedHealthCare)
Used for medical visits and emergencies such as scratched corneas and eye infections.

Most medical insurances do **NOT** cover the routine refraction (\$40 fee out of pocket). Some medical plans may require a referral to be seen at our office.

Contact Lens Evaluation Fees:

Contact lenses are a medical device regulated by the Food and Drug Administration and require a valid prescription by an optometric physician. Evaluating your eyes for contact lens use is considered an additional service that is often not covered by insurance as part of a routine eye exam. Therefore, there may be an additional fee if you choose to be evaluated for contact lenses.

The contact lens evaluation fee is due at time of service and includes a set of diagnostic lenses and follow up appointment, if needed. The evaluation fee is determined by the complexity of the evaluation. This fee does NOT include a supply of contact lenses. First time contact lens wearers must successfully complete an "Insertion and Removal" class with a staff member before the trial lenses can be released to them - this is an additional \$30 fee.

Once the prescription is finalized by the patient and doctor you are entitled to a copy of your prescription.

I understand I am responsible for the contact lens evaluation fee, and insertion and removal fee (if required) **at time of service.**

I understand once my prescription is finalized I am entitled to receive it.

Eyeglass Policies:

Glasses are ordered and custom made specifically to address each patient's needs. The patient has 30 days to notify the office if there are any changes they wish to make. Since the original lenses were custom prescription items which must be discarded, there are no refunds of the difference in cost if the remake pair is of lesser value.

Our full eyeglass policies are available to review in person or online. Please ask the front desk or optician any questions you may have.



Acknowledgement of Notice of Privacy Practices

According to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you may request a copy of your medical record in writing. We will not disclose your records to others unless given your written consent or legal authorities authorize or compel us to do so. Our full Notice of Privacy Practices describes how your health information may be used or disclosed and is available upon request at our front desk.

- I acknowledge that I have had the chance to review and agree to the terms and conditions of the Notice of Privacy Practices and upon request I may have a copy.
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Authorization/Responsibility Agreement

Please check all boxes

- I understand that my portion is to be paid at the time services are rendered. The undersigned will be responsible for any bill incurred in this office regardless of insurance. In the event a claim is denied I am responsible for the fees.
- I understand I am responsible for obtaining a referral if required.
- I understand that screening tests may not be covered by my insurance and that I will be responsible to pay in full for these tests.
- Professional services are not refundable and all product sales are final. Any returns that are approved may be subject to a restocking fee.
- I understand that due to being a custom made product my eyeglass order may not be eligible for any refunds or returns.
- I authorize payment from my insurance to be paid directly to Primary Eyecare Associates. I understand that billing any out of network insurance will be my responsibility. I understand that all 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.

Patient Name:

Guardian/Guarantor Name (if applicable):

Signature:

Date:

DISCLAIMER: By typing your name above, you are signing this form electronically. You agree that your electronic signature is the legal equivalent of your manual signature on this application.

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EYECAREASSOCIATES