Patient Financial Responsibilities and Office Policies

+At Infocus Eye Care our goal is to provide the finest possible eyecare while maintaining the highest level of professionalism to best serve you and your family. We provide:

- Routine eye examinations
- Medically related eye examinations
- Complete contact lens examinations

It is important for our patients to understand the difference between routine eye examinations and medically related eye examinations. We are a provider for most major vision and medical insurance plans. For a complete list of accepted insurances please ask a staff member.

Routine Eye Examinations

A routine eye examination is for the following:

Nearsightedness – Farsightedness – Astigmatism – Presbyopia – Eyeglasses – Contact Lenses

A routine eye examination does NOT cover diagnosis, management, or treatment of medically related eye diseases even if the issue effects your vision.

Please note: If you come in for a routine eye examination and a medical eye condition is diagnosed at that time, additional visits will be needed for further diagnosis, management, and possible treatment.

Medically Related Eye Examinations

Medical insurance coverage is used to pay for eye care when:

- There are specific concerns that are medical in nature
- There is a previously diagnosed medical condition of the eye
- Health conditions are present that damage the eye

Examples include:

Cataracts – Glaucoma – Diabetes – High Blood Pressure – Dry/Irritated Eyes – Allergies – Conjunctivitis (Pink eye) – Flashes/Floaters – Eye Related Trauma & Injury – Foreign Body Removal

Please note: If you are using any insurance for which we are a provider, routine eye examination coverage cannot be used the same day as medical eye care coverage and additional visits will be required.

I have read and understand the differences between routine eye examinations and medically related eye examinations. I also understand that my eye doctor is a provider for both Vision and Medical insurances and will bill the appropriate insurance according to insurance guidelines.

Initial_____

Consent to Treat: I request and give consent to Infocus Eye Care to provide and perform such medical and vision eye examinations, tests, procedures, medications, and other services and supplies as are considered medically necessary or beneficial for my eye and vision health.

Initial_____

Fees: Our office is committed to providing the best treatment for our patients. Our fees are representative of the usual and customary charges for the level of service provided, materials prescribed, as well as the level of advanced technology used to provide our patients with the most modern eye care in our area.

Refraction: Medicare and most other medical insurance plans no longer pay for refractions. Refraction is the test that is performed during your office visit to determine your best possible vision ("which is better, one or two?"). A refraction is also required to determine the health of your eyes and may be necessary in certain Medically Related Eye Examinations. You may be asked to pay for the refraction at the end of your visit. If we do not collect this fee at the end of your visit, you may be sent a statement after we receive your explanation of benefits if this is a non-covered service with your insurance. Refraction is covered by most vision insurance plans as part of a Routine Eye Examination, but not as part of a Medically Related Eye Examination. Please ask a staff member if you are unsure whether a Refraction will be billable to your insurance for today's visit. **The fee for this test is $35.00.**

Please Turn Over and Complete Other Side

Non-Covered Services: Please be aware that some, or perhaps all, of the services you receive may be uncovered or not considered reasonable or necessary by Medicare or other medical and vision insurers. These services may be required to be paid in full at the time of your visit or after we receive your explanation of benefits.

Payment: You are responsible for any applicable co-pays, co-insurance, unmet deductible amounts and any non-covered services. Any surcharges for spectacle upgrades or contact lens overage amounts set by your vision insurance must be paid at the time of service before any orders will be processed. If you are a self-pay patient or your insurance cannot be verified prior to your appointment you will be required to pay in full the day services are rendered. We accept Cash, Personal Checks, MasterCard, Visa, Discover, American Express and Care Credit. If a personal check is rejected (bounces) due to insufficient funds; a fee of $25 will be applied to the patient's account in addition to the amount of the check and we will not accept personal checks again from the patient for the duration of their care. If you are being seen for any ongoing medical problem, applicable co-pays or office visit costs are due at each and every visit. Although rare, any standing positive balance on an account that results from overpayment by the patient or insurance will either be reversed to the applicable insurance or issued as a credit on the account.

Claims Filing: As a courtesy to our patients, we will file claims with insurance companies for which we are a provider. Our office makes every effort to accurately verify benefits for services and/or materials, however, **benefits quoted by your insurance carrier are not a guarantee of payment.** If you have coverage under multiple insurances and/or policies and your primary policy denies a claim, either completely or partially, the remaining balance will automatically be forwarded to an applicable secondary policy. Should your insurance(s) deny a claim for any reason, you will be responsible for any remaining balances as directed by your insurance. Patients that receive a statement from our office are expected to remit full payment upon receipt. If your account must be referred to an outside collection agency for non-payment, a fee will be added to your account to cover the expense incurred from the agency. Patients in collections will not be seen for further care until their balance is paid in full. If you receive a billing statement that you do not understand, please contact our office. Our office will NOT bill for services, Vision or Medical, post service date. While our office is happy to provide any appropriate documentation for the services in question; if a patient would like to retroactively apply insurance benefits to a transaction they must do so themselves. Our office will not offer any refunds or adjustments to already paid funds for the purpose of filing for insurance benefits after the date of service and the items in question will be treated as a non-insurance transaction. We are required by law to get an up-to-date copy of your insurance card(s) prior to any services being provided. If you do not present this at the time of your visit or provide us with inaccurate insurance information, you will be responsible for the balance of the claim.

Non-payment: If we do not receive payment from your insurance company within 60 days, the balance will automatically be billed to you. If your account is over 90 days past due, you will receive a letter stating that you have 21 days to pay your account in full. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency. If this is to occur, you will be notified by regular and certified mail that you have 30 days to pay your balance in full. During that 30 day period, our office will only be able to treat you on an emergency basis.

Missed Appointments: Once your appointment has been confirmed it will be reserved for you to meet your eye care needs. Please be courteous to our staff and fellow patients by keeping your confirmed appointment. If you are unable to keep your confirmed scheduled appointment; we do ask for a 24 hour notice of cancellation. If more than one occurrence of a missed appointment without notice happens **you MAY be charged a $30.00 fee.** If more than 3 missed appointments happen within a 12 month period you will be dismissed from our care.

Insurance Reimbursement: I authorize Infocus Eye Care to act as my agent in applying for insurance benefits both commercial and government sponsored, and I authorize payment of these benefits directly to Infocus Eye Care on my behalf. I authorize any holder of medical information about me to release information needed to determine benefits payable for related services. If I have additional insurance policies, my signature authorizes the release any pertinent medical or personal information to the insurer and/or their agents in order to file for benefits and authorizes my doctor to act as my agent above.

With my signature below I confirm that I have been informed and agree to the above outlined policies and insurance regulations set forth by my provider, insurance and applicable law. Unless revoked by me in writing, this authorization is effective for my lifetime. I have been provided a copy of the Infocus Eye Care Patient Financial Responsibilities and Office Policies.

Patient's Printed Name:_____

Signature (Patient/Legal Guardian):_____ **DATE:**_____