

Visual Perceptions Eyecare Practice Policies

PLEASE READ & SIGN THE FOLLOWING INFORMATION

FINANCIAL POLICY

Visual Perceptions Eyecare will file claims to your insurance, when applicable, as a courtesy to you. It is important for you to understand that the contract exists between you and your insurance carrier. The staff will attempt to verify your benefits and coverage prior to your visit, however, there is no guarantee that your insurance company will pay for all services rendered by our facility. We require that copays be paid at the time of service and will send you a statement for any uncovered charges after insurance has responded to our claim.

Private pay patients are expected to pay in full at the time of service unless prior arrangements have been made.

Refraction is a test used to determine what prescription lenses will best correct a patient's vision, resulting in the patient's glasses prescription. Many medical insurance companies do not cover the cost of refraction, currently set at \$45.00, and patients will be billed this amount upon denial from their insurance company.

Routine vision may or may not be covered by your medical insurance plan. We will attempt to verify coverage for routine eye exams before your visit. If there is no medical diagnosis found during your exam, and your insurance company does not provide routine coverage, you will be responsible for the charges upon denial from your insurance company. Vision plans (such as VSP, Eyemed, Spectera, etc) may cover routine vision, but will not cover any further medical testing. If there is a medical diagnosis found, and the doctor believes further testing is necessary, we will have to bill your medical insurance.

Visual Perceptions Eyecare maintains a returned check fee policy of \$25. Any patient with two returned checks will no longer be able to pay by check.

ASSIGNMENT OF BENEFITS

- I understand that I am fully financially responsible for any and all charges incurred during the course of authorized treatment.
- I further understand that all applicable fees are due on the date that services are provided and agree to pay such charges in full.
- I hereby assign all medical and surgical benefits to Visual Perceptions Eyecare, including major medical benefits, to which I am entitled.
- I authorize and direct my insurance carrier(s) to issue payment checks to Visual Perceptions Eyecare for medical services rendered to myself or minor children.
- I understand that I am responsible for any amount not covered by my insurance benefits.

AUTHORIZATION TO RELEASE INFORMATION

- I authorize Visual Perceptions Eyecare to release any information necessary to insurance carriers regarding my treatments, process insurance claims generated in the course of examination, and allow a photocopy of my signature to be used to process insurance claims for the period of my lifetime.
- I authorize Visual Perceptions Eyecare to disclose protected health information, including lab results and diagnoses, in messages left on my voicemail at the following number (____) _____-_____, and to the following person(s) _____. If you would like an alternative form of communication, please state it below

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed Visual Perceptions Eyecare's Notice of Privacy Practices provided behind this paperwork, which describe how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document if I ask for one.

Patient Signature: _____ **Date** _____

Clinic Representative: _____ **Date** _____