VISUAL PERCEPTIONS PRACTICE POLICIES

FINANCIAL POLICY

Visual Perceptions 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 & your insurance carrier. The staff will attempt to verify your benefits & 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 copayments be paid at the time of service & we 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.

A refraction is a test used to help determine what prescription lenses will best correct a patient's vision, resulting in the glasses prescription. Many medical insurance companies do not cover the cost of a 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 (VSP, EyeMed, Spectera, etc.) may cover routine vision, but will not cover any further medical testing. If there is a medical diagnosis found, & the doctor believes further testing is necessary, we will have to bill your medical insurance. **There is no way to determine a medical diagnosis until the exam is complete.**

Visual Perceptions maintains a returned check fee policy of $25.00. Any patient with two returned checks will no longer be able to pay by that method.

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 & surgical benefits to Visual Perceptions, including major medical benefits, to which I am entitled.
- I authorize & direct my insurance carrier(s) to issue payment checks to Visual Perceptions for medical &/or routine 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 to release any information necessary to insurance carriers regarding my treatments, process insurance claims generated in the course of examination, & allow a photocopy of my signature to be used to process insurance claims for the period of my lifetime.
- I wish to authorize Visual Perceptions to disclose protected health information, including lab results & diagnoses, in messages left on my voicemail at the following number (____) ____-______, & to the following person(s) ______________________. If you would like an alternative form of communication, please state ____

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed Visual Perceptions' Notice of Privacy Practices provided on the wall next to the check in window, which describes how my medical information will be used & disclosed. I understand that I am entitled to receive a copy of this document if I ask for one.

Patient Signature: ____ **Date:** ____________________

Patient Print: ____ **Date:** ______________________

Clinic Representative: ____ **Date:** ______________________