Cataract and Family Eye Care

Name:_____DOB:_____SSN_____-____-_____Sex: M or F

Insurance Information

Primary Insurance_____ID#_____Subsriber/DOB_____

Secondary Insurance_____ID#_____Subscriber/DOB_____

Referral Needed? Y N Coverage for Routine Eye Care? Y N

Authorization for assignment of insurance benefits:
I authorize Cataract and Family Eye Care to submit to my insurance and assign the benefits to be directly paid to Cataract and Family Eye Care when applicable. I am responsible for all referrals, co-pays, deductibles, and non-covered procedures and devices provided on the date of service.
Initial: _____

Notification of Privacy Practices:
I hereby acknowledge that I have received/read a copy of Cataract and Family Eye Care, LLC. Notice of Privacy Practices. **Initial: _____**

Refraction Billing Policy - "Refraction" is the process of determining the strength of the prescription for your glasses. A refraction is also an important tool that aids in the diagnosis and treatment of many eye conditions. **However, most insurers INCLUDING MEDICARE classify this as a NON-COVERED SERVICE and require that patients be responsible for payment.** Federal guidelines require that refractions be billed separately for all patients.

Our staff is expected to collect payment for refractions, currently **$30.00**, on the day of service. This is IN ADDITION TO any co-pay you may have. **Initial:_____**

Contact Lens Billing Policy- Contact lenses need to be checked for a proper fit once a year because the shape of the eye can change, and this may cause contact lenses to erode the surface of the eyes or to over-tighten on the surface of the eyes. For insurance purposes, contact lenses are considered cosmetic and, therefore, the process of checking them and making any necessary adjustments to the contact lens prescription is not a covered service. **Initial:_____**

Fee schedule for contact lens-related services:

Established contact lens wearer	$ 50.00
Refitting of established contact lens wearer	$ 75.00
New contact lens fitting (basic, spherical contacts)	$150.00
New contact lens fitting (astigmatism or multifocal)	$175.00

Patient Waiver and Authorization: I understand that a refraction and contact lens examination are non-covered services and agree to comply with the above policy. I accept full responsibility for the cost of the service. **Initial:_____**

In signing below, I acknowledge that I have read and understand the above policies of Cataract and Family Eye Care.

Signature:_____Date:_____