Financial Policy – Lifetime EyeCare - You should read these terms carefully

Please give the receptionist your insurance cards (vision and medical) to scan . We must have the correct insurance information in order to file your insurance. By law, every year, we need a current copy of your insurance card in your record.

Vision Insurance: ____

Insured Name: ____

Insured Date of Birth _________________________ Insured SSN _____________________________

Medical Insurance: ____

Insured Name: ____

Insured Date of Birth _________________________ Insured SSN _____________________________

Remember, insurance is considered a method of reimbursing the patient for fees paid to the doctor, and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charges.

It is your responsibility to pay for deductible amounts, coinsurance or any other balance not paid by your insurance. WE DO NOT CARRY ACCOUNTS.

- I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. All other information will be kept confidential unless a medical release is signed by you.
- I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled including Medicare, private insurance and other health plans to Lifetime EyeCare. Please understand that your insurance policy is a contract between you and your insurance company and that YOU are responsible for your charges.
- This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.
- I understand that I am financially responsible for all charges whether or not paid by said insurance.
- I understand that if I choose contact lenses, professional services are nonrefundable.
- I agree to pay all charges incurred at conclusion of each visit. I agree to the assignments and financial responsibilities shown above.

If you have any questions, please ask, if not, then you are in agreement with the terms of this financial policy.

Signature: ____ Date: _________________________

I am aware of the privacy policies of Lifetime EyeCare.

Signature: ____ Date: _________________________

By signing this form, I consent to treatment for **myself** and/or on behalf of the minor for which this information pertains. I give permission for the doctor/s to examine, diagnose, and initiate treatment as deemed appropriate. I further attest that I am the Legal Guardian of the minor and have the authority to authorize care and treatment. I understand the Office Policy. In the case of separated or divorced parents, the parent bringing the child into the office is financially responsible for all charges incurred.

Signature: ____ Date: _________________________

Should medical records need to be released, who may we release these records to?

_____ insurance company _____ another doctor's office _____ employer _____ Other

Signature: ____ Date: _________________________

COVERAGE OVERVIEW

As one of Medicare Part B eligible beneficiaries, Medicare may be your primary or secondary health insurance. By law, we are required to file for covered services to Medicare on your behalf. For your convenience, our office participates with the Medicare program. This means we will bill Medicare for your medical office visits, tests and materials. Medicare will review all the submitted claims and, if approved, reimburses our office directly 80% of the approved amount. The remaining 20% is your responsibility as the Medicare beneficiary. You may also be responsible for a deductible and certain routine/screening non-covered feels as described below. Our office may elect to:

1. Bill you directly for our portion of the fees, or
2. Bill your supplemental/secondary insurance if you carry it.

DEDUCTIBLE

Medicare Part B has a yearly deductible, which is subject to change yearly. If our office is the first to submit Medicare claims on your behalf for a new year, and the charges are applied to your deductible, we are required by law to collect the Medicare approved amount.

REFRACTION/OBTAINING YOUR SPECTACLE PRESCRIPTION

Part of your exam will include a refraction in order to determine your spectacle prescription. This portion of the exam is NOT covered by Medicare. This fee is due on the day of your exam.

MEDICARE WAIVER/SIGNATURE AUTHORIZATION

I request payment of authorized Medicare benefits be made either to me or on my behalf to Lifetime EyeCare for any covered services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

I understand Medicare will NOT cover any services determined as routine/screening. I understand I will be financially responsible for these charges. These services NOT covered include: refraction, routine eye exams, glasses and contact lenses, replacements, non-medical necessary tints, scratch coatings, progressive lenses and/or additional patient options for glasses, contact lenses cleaners and solutions.

MEDICARE/MEDIGAP BENEFITS

I request that payment of authorized Medigap benefits be made either to me or on my behalf to Lifetime EyeCare for any services furnished to me. I authorize any holder of medical information about me to release to

__________________________(Medigap Carrier) any information needed to determine these benefits or the benefits payable for related services.

These assignments will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Signature: ____ Date: _______________________

Patient/Legal Guardian