S EYE | CARE
Know Your Options

Welcome!

689 Yorktown Road – Ste 104
Lewisberry, PA 17339
717 - 932 – 2020

Patient		***Address***		***Phone***	
Last	______	Street	______	Home	______
First	______	City	______	Work	______
MI	______	State	______	Cell	______
DOB	______	Zip	______	E-Mail	______
SSN	xxx - xx - ______				

Primary Insurance Coverage Determination

____ ***Medical Insurance*** is considered the primary billing party if you have *any eye problems/symptoms or eye disease*, new or established, or if you have any medical conditions, such as *diabetes*, or are undergoing medical treatment, such as high risk medications, that are known to cause eye problems, that require evaluation and management. Medical insurance is also primary for any procedure(s) deemed medically necessary by the doctor to manage and treat current eye disease. The patient or guarantor is responsible for the specialist co-pay and any co-insurance and/or deductible the patient's medical insurance requires. We do not inquire about the aforementioned financial agreement between the insured party and insurance company; it is the responsibility of the insured party to be familiar with their contract.

____ ***Vision Benefit Plans*** may be utilized for basic ocular-vision wellness exams, which include screening tests for ocular disease and refraction. The primary purpose of a vision benefit examination is to measure your current visual status, not evaluate and manage a non-refractive diagnosis. A *Vision Benefit Plan* supplements Major Medical Insurance.

Refraction Policy

A refraction is an important test to determine the eye's refractive error or best corrected visual acuity and helps determine the cause for reduced vision, either refractive or disease. Your medical insurance may be billed for this procedure, excluding Medicare, and then forwarded to your vision benefit plan, if allowed, for coverage, but ultimately it is the financial responsibility of the patient if it's determined to be a *non-covered service*. Our office fee for refraction is $30 and is in addition to any medical co-pay, co-insurance or deductible to be collected for the date of service.

Contact Lens Patients

In accordance with the *Fairness to Contact Lens Consumers Act*, a contact lens prescription will be issued after a contact lens fitting and/or evaluation has been finalized and balance paid by the guarantor for services rendered or upon verification of insurance coverage for payment of services rendered. In Pennsylvania a contact lens prescription expires at 1 year.

Billing Process

Using the information you have supplied us, including insurance cards & the primary insured's information, your insurance will be billed on your behalf with insurance benefits paid to S Eye Care, P.C. After receipt of payment and/or denial as itemized on the insurance "explanation of benefits", if necessary, you will be billed in accordance with your insurance contract for any applicable co-pay, co-insurance, non-covered service or deductible. Please make all payments within 30 days of receipt of your statement. Returned checks will incur a $25 fee and will automatically be applied to your account.

Reason(s) for Today's Office Visit: ❑ I do not have any ***new*** concerns.

I am experiencing ***new***:

- ❑ Blurred Vision
- ❑ Double Vision
- ❑ Vision Loss
- ❑ Floaters/Spots
- ❑ Flashes
- ❑ Headaches
- ❑ Red Eye(s)
- ❑ Dry Eye(s)
- ❑ Eye Irritation
- ❑ Lid Irritation

❑ I have Diabetes
Last blood sugar? ________mg/dL
Last HbA1c ? ________%

Primary Care Physician:
Dr. __________________________

Other:

I would like to update my:

- ❑ Eyeglass Prescription
- ❑ Contact Lens Prescription
- ❑ I do not wear corrective lenses

I would like to purchase new:

- ❑ Eyeglasses
- ❑ Contact Lenses

iWellness Retinal Scan
❑ Approve ❑ Decline ________ *initial*

I have read, understand and agree to the above Financial Policy. By signing below, I understand the charges not covered by my insurance, including applicable co-payments, co-insurance, deductible & non-covered services are my responsibility.

________________ ________________________________

Date Signature (Patient or Guarantor)