# 2022

# DaVinci Eye Care, LLC

600 Louis Dr, Ste 203A ● Warminster, PA 18974
O: 215-443-8580 ● F: 215-672-7526

I request that payment of authorized Medicare and/or other insurance benefits be made to DaVinci Eye Care, LLC for any services rendered by them to me. I authorize the release of medical information to my insurance company so that benefits can be paid to the doctor.

***I understand DaVinci Eye Care will bill either my medical insurance OR vision plan insurance based on my medical history and/or chief complaint.***

*A vision exam constitutes a comprehensive examination of my eyes and may include glasses or contact lenses.*

*An examination is considered a medical eye exam when a medical condition exists or is suspected to exist. These medical conditions include, but are not limited to: diabetes, glaucoma, cataracts, macular degeneration, unexplained changes in vision, headaches, eye turn, lazy eye, inflammation, pain in or around the eye(s), pink eye, allergies, itchy eyes, etc. Any examination related to a medical problem or condition will be billed to my medical insurance.* _____**Initial**

I understand I am responsible for any amount not paid by my insurance company, including but not limited to co-pays, deductibles and/or coinsurance. If payment for any outstanding balance is not made within 30 days of receipt, I will also be responsible for any late or collection fees. I understand DaVinci Eye Care will make every effort to verify and check insurance eligibility, but it is ultimately the subscriber's responsibility to be aware of any co-pays and/or deductible amounts. _____**Initial**

A refraction is performed to determine if there is a need for corrective eyeglasses. If you are here for a medical visit, this is NOT a covered service by Medicare or most medical plans. Our fee for the refraction is Fifty Dollars. _____ **Initial**

DaVinci Eye Care now participates in a secure online web portal in which you have electronic access to your most recent exam records. The link to the online portal can be found at davincieyecare.com.

_____

*E-mail Address*

I have received a copy of the Privacy Policy (HIPAA) or may receive a copy by contacting DaVinci Eye Care, LLC.

A copy of this signature is as good as an original.

***Signature:***_____

**Name (Print):**_____

**Date:**_____ *(OVER)*

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I, _____, authorize DaVinci Eye Care to release my/ _____ (if signing for a minor) medical records and any other medical information to the following individuals:

| | |
|---|---|
| _____ | _____ |
| Name | Relationship |
| _____ | _____ |
| Name | Relationship |
| _____ | _____ |
| Name | Relationship |

I understand that I am responsible to notify DaVinci Eye Care of any privacy changes in the future.

***Signature:***_____

**Name (Print):**_____

**Date:**_____