NORTH COAST EYE CARE

Patient Medical and Financial Responsibility Agreements

Thank you for choosing North Coast Eye Care for your vision and medical needs. We are committed to providing you with the highest quality of vision and medical care. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies, authorization agreements and payment policies.

1. I hereby authorize and consent to medical treatment by North Coast Eye Care (NCEC) for myself (or my child). I authorize NCEC to release my (or my child's) medical information to my (or my child's) family doctor and to any insurance company, adjuster, attorney, authorized agent working on behalf of NCEC, or other authorized party.

   Initial: _____

2. I understand that I am responsible for payment of all medical treatment rendered to me (or my child) by NCEC, and I agree to pay all co-payments, deductibles, and non-covered services in full at the time of the visit. In the event that I am seen at any time by NCEC without a referral, I understand that I am financially responsible for all charges incurred. I understand that an insurance authorization is an estimation of coverage, and that final out of pocket amounts may vary based on actual insurance payment and processing. Both Vision and Medical insurance coverage must be presented prior to the time of service. Any insurance information presented after the date of service will not be accepted. A fee of $30.00 will be charged for all returned checks.

   Initial: _____

3. I understand that payment is expected at the time services are rendered, including non-covered portions of insurance. Please note: most insurance policies pay only a portion of your total charges. If you have questions about your coverage, please contact your insurance representative. While we do verify insurance benefits prior to your appointment, we cannot guarantee the accuracy of the information provided. Please understand that financial responsibility for your account is ultimately yours, not that of your insurance company. We are pleased to be able to provide the service of filing a claim with your insurance company and forwarding any remaining patient balance if your insurance company determines there to be one. Accounts 90 days past due are subject to collection fees and will be transferred to a collection agency. In the event that I fail to meet my financial obligations, I agree to pay attorney and/or collection agency fees plus court fees and any additional collection fees.

   Initial: _____

4. <u>"Refraction"</u> – **This service, while not covered by most insurance companies, is an integral part of the eye exam. It aides your physician in determining the cause of any changes in your vision, therefor it is necessary and not optional.** The determination of the best corrective lenses to be prescribed or a change in your eyeglass prescription (CPT code 92015) is a separate charge in addition to an eye exam. Most insurance companies consider this a "non-covered" service.

   Initial: _____

5. Eyeglasses Rx Changes: - Recheck visits after 180 days will be charged the usual fee for a brief exam. **If a North Coast Eye Care's prescription is filled elsewhere, and a Rx change is needed, we will not be responsible for any charges incurred.** Most reputable optical dispensaries allow doctor Rx changes at no charge, but it is up to the patient to inquire about such policies in advance of purchase.

   Initial: _____

6. Eyeglasses Made Through North Coast Eye Care - We will start your custom glasses order immediately. For this reason, cancellation on glasses may incur lab charges. All cost incurred once the order has been started at the lab whether or not completed will be the customers responsibility. All glasses are custom crafter for each patient with their unique prescription. All glasses lenses are custom cut to fit the frame chosen. Therefore, patient may not switch frames after their lenses have been cut.

   Initial: _____

7. Contact Lens Fees - Contact lens evaluation services may not be included as part of your routine vision benefit and additional fees may apply. **Fees are determined according to the complexity of the case and the predicted time necessary to care for the individual patient, as well as the number of follow up visits required.** To be fit into contact lenses, a corneal evaluation and refraction must be completed by North Coast Eye Care. If going forward with a contact lens exam today, there will be another form to sign.

   Initial: _____

8. Medical vs. Routine Benefits – A routine eye exam is defined by insurance companies as an office visit for the purpose of checking vision, resulting in diagnosis such as "nearsightedness", "farsightedness", or "astigmatism". A medical eye exam is defined by a diagnosis such as "dry eye", "glaucoma", "cataracts", or "AMD". This list does not include all possible medical findings. If you have an issue that is a medical condition(s), or we are currently following you for a medical condition(s), then medical insurance will be billed. This will be discussed with you during the examination. **We are not able to guarantee that any medical finding will or will not be found during the exam and will not know which insurance will be billed until after the Doctor has examined you.**

   Initial: _____

***Pupil dilation may make you more sensitive to sunlight and can last from 4-8 hours. We will be happy to provide a complimentary pair of disposable sunglasses. If you feel that driving may be impaired, please discuss this with the doctor prior to dilation. ***

By my signature below and my initials above, I hereby authorize assignment of financial benefits directly to North Coast Eye Care and any associated healthcare entities for services rendered as allowable under the standard third-party contracts. I understand that I am financially responsible for charges not covered by this assignment.

Print Patient Name: _____

Date of Birth: _____

Patient Signature: _____

Parent/Guardian Signature: _____

Date of Signature: _____