



Visionary Eye Doctors Patient Agreement, Office & Financial Policies

Thank you for choosing Visionary Eye Doctors. We are committed to providing you with the best eye care possible. In order to accomplish this, we need your assistance in understanding our practice policies.

1. Cancellations and Late Arrivals:

If you must cancel your appointment, we ask that you notify us within 48 hours of your appointment so that we may offer that time to another patient. Failure to notify us at least 24 hours in advance may result in a \$35.00 missed appointment fee. Missed appointments are subject to a prepayment charge **prior to rescheduling** and cannot be filed to insurance.

If you are more than 30 minutes late to your scheduled appointment, we will make every effort to accommodate you, however, we may have no choice but to reschedule your appointment. We thank you for your understanding.

Patient Initials _____

2. Insurance & Patient Responsibility for the Bill

Visionary Eye Doctors contracts with or accepts most insurance plans. While we strive to educate our patients on their insurance benefits, **it is THE PATIENTS RESPONSIBILITY to be aware of their insurance benefits including deductible, office visit copays and referrals required by insurance.**

All patients are financially responsible for the timely payment of all charges incurred. For those patients with insurances accepted by our doctors, Visionary Eye Doctors will submit the bill to the patient's insurance company first for payment. All services not covered by your insurance will be your responsibility and billed to you in accordance with your specific insurance policy.

Payment is due at the time of your visit for any co-payment, deductible or coinsurance amount. Your deductible is the amount you pay OUT OF POCKET for covered health care services BEFORE your insurance plan starts to pay. **Unless other payment arrangements have been made with our billing department, we require patients to pay their co-pay, deductible and all out of pocket expenses BEFORE leaving the office.**

Any and all outstanding balances must be paid, or payment arrangements made and in good standing, at the time of check-in, or your appointment will be rescheduled, and you will be charged a **cancellation fee of \$35**. Failure to pay outstanding balances within 90 days may result in the practice forwarding your account to a collection agency of our choosing and may result in additional fees being charged to your account.

Patient Initials _____

3. Referrals

Referrals must be presented at time of check-in before proceeding with the visit. It is the patient's responsibility to ensure they have a valid referral for their visit, and to know how many visits are allowed, and expiration date of their referral. We cannot bill your insurance without a valid referral, and you may be asked to reschedule your appointment. **If you choose to be seen without a valid referral, payment for services rendered at your visit are due at the time of checkout.**

Patient Initials _____

4. Non-Covered Services & Point of Service Collection

Payment for non-covered services, such as refractions or contact lens fittings, is due at the time services are rendered. We accept, cash, checks, and major credit cards for your convenience. Any outstanding balances are also due at the time of service. If you have a question about your outstanding balance, our Business Office will be more than happy to assist you.

If we suspect that a service may not be covered by your insurance company, for example many dry eye procedures are seen as experimental and are therefore not covered by most insurance plans, we ask that you sign a form in advance acknowledging that you have been advised the service may not be covered and that you accept financial responsibility. This applies to all services your doctor feels are needed in your treatment plan, but that your insurance company may deem non-covered, experimental and / or cosmetic in nature.

Please Note: Payment for all cataract surgery, refractive surgery (LASIK, PRK), and most elective procedures is due 2 weeks prior to services being rendered. Surgical procedures cancelled within one week of surgery will be assessed a cancellation fee based on proximity to surgery date.

Patient Initials _____

5. Refraction and Additional Fee

The refraction is part of your eye examination during which the doctor or technician offers you a series of lens choices to choose from until you reach your best corrected vision. This is to assess the overall health of your eyes and helps the doctor determine if your vision has changed. If you are experiencing blurred vision or decreased visual acuity as measured by the eye chart, a refraction will help determine whether the difficulty is the result of a medical problem, a need for an updated glasses prescription, or a new contact lens prescription.

Medicare and other forms of insurance do not consider a refraction to be part of a comprehensive eye exam. **Medicare will not pay for this service but requires eye doctors to charge separately for it and has enforced this policy since 2007.** As many private insurance carriers adopt the policies of Medicare, **your secondary coverage will not cover a refraction if Medicare does not.** If a refraction is a necessary part of your exam today, we will perform it and you will be **charged a fee of \$67.00** today at check-out.

Patient Initials _____

6. Vision Insurance vs. Medical Insurance

When scheduling an appointment with Visionary Eye Doctors, you are usually coming in for one of two reasons: your annual routine visits or you are having a medical eye problem. Please let us know what your primary concern is for your visit so we can help you maximize your benefits and obtain the correct insurance information.

Please note all copays, deductibles & co-insurance fees are due at the time of your visit.

a. Vision Plans

Vision plans are for routine visits where you do not have any medical issues, problems, or diagnoses. We participate with VSP, EyeMed, Davis Vision, March Vision, Avesis, Superior Vision and National Vision Administrators (NVA) Vision plans. **Please inform us if you have a vision plan and the name of the plan BEFORE your exam.**

Most vision insurance plans include the following benefits either annually or every two years:

- Annual eye exams: **May not cover dilation** portion of exam if required by doctor.
- Eyeglass frames: May be purchased at a discount depending on plan benefits.
- Eyeglass lenses: May be purchased at a discount depending on plan benefits.
- Contact lenses: May be purchased at a discount depending on plan benefits.

Many vision plans **do not cover** annual contact lens evaluations or contact lens fittings for first time wearers or established wearers that need to switch to a new brand.

b. Medical Insurance Plans

Medical insurance is used if you have an eye disease or medical condition is present that causes eye problems. Some common conditions for which we may bill your medical insurance include:

- Redness
- Flashes & floaters
- Allergies & itchiness
- Dryness
- Infections
- Monitoring cataract development
- Diabetic Eye Examination
- Examination of patients using medications with potential eye side effects, such as steroid medications, arthritis medications, etc.
- Patients that are at high risk for glaucoma development
- Patients with macular degeneration

Unfortunately, due to insurance company policies you cannot use your vision and medical insurance for a joint exam on the same day. The only exception to this is patients who have VSP Vision insurance.

Below are two possible alternatives:

1. We can schedule your **medical and vision exams on separate days** or bring you back for a separate visit from your annual wellness exam to treat any medical concerns. If you return on a separate day, parts of your exam may be repeated due to minimum visit requirements by law.
2. If you need to schedule your **medical and vision visits on the same day**, we will bill your medical insurance for the medical exam portion, and you will be charged the additional flat rate fee of \$67.00 for a refraction if needed.

Patient Initials _____

7. Pediatric Patients (If applicable)

A minor child needs an agreement signed by a parent or guardian. By signing the agreement, the parent or guardian assumes responsibility for information on behalf of the patient. We require a parent or guardian accompany a minor under the age of 18 to all appointments. Visionary Eye Doctors reserves the right to request identification of any adult accompanying a minor.

Parent or Guardian Initials _____

Authorization for use of Patient Contact Methods

We might be unable to contact patients directly during normal business hours. On these occasions, our office contacts patients and leaves messages through the communication devices provided by our patients. Due to the new federally mandated HIPAA Privacy Rule, we must obtain your authorization to continue this mode of communication. Protected Healthcare Information that we may possibly disclose on your home, work, cell phone, or email account includes, but is not limited to test/lab results, prescription/pharmacy information, appointment instructions for visits and procedures, and surgical posting/scheduling information.

Please check ONE box below:

() **Yes**, I agree to allow Visionary Ophthalmology, doing business as Visionary Eye Doctors, to leave messages that include Protected Healthcare information on any of these communication devices: home phone, work phone, cell phone, and/or email account.

No, I do not agree to allow Visionary Ophthalmology, doing business as Visionary Eye Doctors, to leave messages that include Protected Healthcare information on any of these communication devices: home phone, work phone, cell phone, and/or email.

Patient Initials _____

Authorization to Participate in Research:

Our office conducts academic research to improve our medical techniques and further contribute to the field ophthalmology. Information used in our clinic, such as photographs, videos, diagnoses, measurements & other relevant information regarding your eyes and general health may be included in our research efforts. Your identity will always be protected. In compliance with HIPAA regulations, your personal information will not be included in our research. Your medical care will not be affected by choosing not to participate in our research efforts.

Please check ONE box below:

Yes, I hereby consent to Visionary Ophthalmology, doing business as Visionary Eye Doctors, to include me in their research efforts.

No, I hereby DO NOT consent to Visionary Ophthalmology, doing business as Visionary Eye Doctors, to include me in their research efforts.

Patient Initials _____

I have read and understood the patient agreement, office and financial policies of Visionary Eye Doctors as outlined above.

Print Name of Patient/Responsible Party

Date

Signature of Patient/Responsible Party

Date