

**WILSON EYE CENTER
FEES & PRIVACY NOTICE**

Please review carefully & Fill out completely.

INSURANCE AUTHORIZATION AND ASSIGNMENT

Various health care agencies such as Medicare, Medicaid, state agencies, and other insurance agencies require the patient to sign a consent form authorizing the release of information to determine claim eligibility and payment to the provider. In addition, various health care agencies such as Medicare, Medicaid, state agencies, and other insurance agencies require full disclosure to inform patients that certain procedures such as refraction for eye glasses and premium type eyeglass frames and lenses may not be covered under the insurance plan and may require an additional co-payment.

I have read the above and foregoing consent for insurance authorization and payment. I do hereby acknowledge that I fully understand the terms and conditions of the consent. **X** _____ (initial)

REFRACTION FEE ACKNOWLEDGEMENT *Note: This may not apply to every patient.*

Many medical insurance plans only cover health evaluations and do not cover routine eye exams for determining glasses and /or contact lenses prescription.

Examples: Medicare does not cover routine eye exams for glasses or contacts.

Regular Medicaid covers routine exams for children up to age of 21, but not for contacts.

Many vision insurance plans that cover routine exams do not pay for the refraction and / or fitting for contacts.

Examples: Spectera— The refraction and fitting is included in the allowance for contacts if the patient receives covered contacts.

If the patient needs contacts that are not covered by Spectera, the patient is responsible for the refraction/ fitting fee. VSP (Vision Service Plan) covers routine eye exams, but contact lens wearers will be responsible for a fitting fee if VSP does not consider it to be a "covered" contact lens fitting.

For those insurance plans that do not cover a routine exam for glasses and / or contact lens evaluation and fitting, Wilson Eye Center charges a separate fee. This fee must be paid before the patient can receive contact lenses, glasses, or the written prescription for either.

Additional Fees for NON- Covered Services:

Refraction /Fitting for Glasses: \$30.00

Refraction /Fitting for Glasses and Contacts: \$30.00-\$150.00 (depending on type of fitting)

I have read and understand the above explanation. **X** _____ (initial)

PATIENT PRIVACY NOTICE

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

This office of Wilson Eye Center (referred to hereafter as the or this "office") is committed to protecting your personal medical information. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care and complies with this office's medical release retention requirements. This notice applies to the medical records maintained by this office and it specifically details the ways in which your medical information may be used and disclosed to third parties. This notice also details your individual rights regarding your medical records.

1. This office may use and/or disclose your medical information consistent with valid consent granted by you for the purpose of:
 - a. Treatment- In order to provide you with the healthcare you require, this office will provide your medical information to those healthcare professional.
 - b. Payment- In order to get paid for services provided, this office will provide your medical information, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements.
 - c. Healthcare Operations- In order to gain an overall view of various elements of this office's operations, individual medical information may be collected, compiled, and disseminated.

By signing below, I certify that I have received and reviewed this notice and all of my questions have been answered to my satisfaction in language that I can understand. **X** _____ (initial)

FINANCIAL POLICY

Person responsible for account: _____ Signature: _____

1. Examination – FULL payment due at time of exam.
2. Glasses – ½ Down on order; balance due in FULL at delivery
3. Contact Lenses – ½ Down on order; balance due in FULL on delivery
4. Office Visits – FULL payment at time of visit

Please check payment type: Cash/Check MC/Visa/Discover/AM Express Medicare Medicaid Medigap Tricare

Vision Insurance: Avesis BC/BS Davis Eyemed Spectera State Merit VBA VSP VSU Other Insurance _____

Name of Individual (Printed) _____ Signature of Individual _____

Signature of Legal Representative _____ Relationship _____
(e.g., Attorney- In- Fact, Guardian, Parent if Minor)

Date Signed _____ Witness Signature _____