ASSIGNMENT OF MEDICAL BENEFITS

1. Comprehensive eye exams include all professional services related to the evaluation and treatment of your eye and visual health. In particular, ***routine eye exams*** (i.e., presenting only with symptoms of blurred vision, without any acute/chronic eye health conditions/diseases) and ***refractions*** (i.e., the determination of your eyeglasses prescription) are usually covered by ***vision insurances***, but NOT ***primary health insurances***. (MEDICARE, for example, does NOT cover either, and they are considered out-of-pocket expenses.) A referral is not a guarantee of payment.

2. **Treatment of eye diseases**, either upon initial presentation or otherwise following the initial comprehensive eye exam, is a **separate billable service**. While treatment of eye diseases is **not covered** by ***vision insurances***, it is usually covered by ***primary health insurances***, including MEDICARE.

   If you have both types of insurance plans, it may be necessary for us to bill some services to one plan and other services to the other plan. We will follow a procedure called ***coordination of benefits*** to do this properly, in order to minimize your out-of-pocket expense.

3. **Contact lens fittings are a separate billable service from comprehensive eye exams** (although they may be rendered on the same day), and a comprehensive eye exam within one year is an obligatory prerequisite for your ***primary health insurance*** including MEDICARE. Any subsequent follow-ups to refine the contact lens prescription are included at no charge for up to 90 days, or up to five follow-up visits, unless otherwise stated at the time of examination.

Patient Name:_____ Relationship:_____

Patient Signature:_____ Date:_____

I assign all of my medical benefits, including all benefits to which I am entitled through Medicare, private insurances, and any other health plans, to **Family Eyecare**. A photocopy of this assignment is to be considered as valid as an original. I authorize said assignee to release all information necessary to secure payment of benefits paid and not paid by my insurance company.

Benefits quoted to me are not a guarantee of payment by my insurance company, and final determination can only be made when the claim is processed. The patient is still responsible for the **co-insurance, deductible,** and any other **non-covered services**. The co-insurance and deductible are based upon the charge determination of the insurance carrier, which can only be confirmed after the claim has been submitted.

I understand that, if some fees are not paid by my insurance, I am still financially responsible and will be billed for them. Accounts 90 days old are subject to collections, and there will be a service charge of $20.00 for any bounced checks. **I understand that it is MY responsibility to know my own coverage.**

Patient Name:_____ Relationship:_____

Patient Signature:_____ Date:_____