GOOD EYE
OPTOMETRY

Policies and Procedures

Appointment Cancellation Policy: If you are unable to keep your scheduled appointment, we ask that you give adequate notice (24 hours when possible, or prior to appointment time on the same day in an emergency situation) so that we may open your reserved time for another patient. If you miss or cancel an appointment once, we will require credit card information prior to scheduling your next appointment. Second missed or canceled appointment will result in a **$49 cancellation fee**. This fee will be billed to you directly.

Late Appointments: We give our patients a 10 minute grace period before they are considered as a missed appointment. If you are late for an appointment within 10 minutes, you will be seen as soon as possible, though the office visit may need to be shortened in length, and only if space is still available and time permits. Dilations may need to be rescheduled for late arrivals.

Medical Products: All sales are **final** for medical products (i.e. warm compress kits, vitamins, lid scrubs, eye drops).

Eyeglass lenses/Frames: Undamaged and unworn frames can be exchanged only, but **no refunds** will be made. A $50 restyling fee will be charged for exchanges. **Prescription lenses are non-refundable**.

Contact Lenses: Contact Lenses are FDA regulated medical devices which may denature and/or damage in certain conditions if not properly handled. Contacts may be exchanged only if boxes are unopened and undamaged. Damaged boxes are at the discretion of management and/or your contact lens manufacturer. Exchanges can only be made if an appropriate contact lens prescription is present within 30 days of initial contact lens purchase.

Medical vs. Vision Insurance

Medical Insurance: When a medical condition exists such as but not limited to cataracts, glaucoma, dry eyes, trauma, red eyes, diabetes, high blood pressure, or any other condition related to the health of the eye, it will be necessary for the doctor to perform a full and comprehensive *ocular health exam*. This exam may include further testing beyond the scope of a routine wellness eye exam. With a medical diagnosis, your exam and testing will be billed to your medical insurance and you will be responsible for any co-pays, deductibles and/or co-insurance as dictated by your specific plan. If you are diabetic, your exam will be billed to your medical insurance without exception.

Vision Care Plan: Vision coverage for a routine examination is designed to provide a screening evaluation of the eye to determine a prescription for glasses only. This evaluation excludes any additional testing to diagnose, evaluate and follow ocular health or medical conditions. This evaluation also does not include a contact lens evaluation or any fees associated with contact lenses.

Refractions: Refraction is the portion of the examination process wherein the doctor places various lenses in front of your eyes to determine your best corrected vision for your spectacle prescription. This service is considered to be a non-covered service by Medicare and most secondary insurance plans. The fee for this service is $95 and is collected when refraction is performed whether or not you have had a change in your prescription. A spectacle prescription is valid for one year from the date of the refraction; you will need to have refractions as part of your exam in order to maintain a current prescription. Prescription re-checks can be granted at no charge within 60 days of the prescription date.

By signing here I acknowledge I have read and understand the Policy and Procedures statements.

_____
Printed Patient Name (and Guardian Name if applicable)

_____ _____
Patient or Guardian Signature Date

Patient Insurance and Financial Responsibility

I understand and agree that payment in full for services and products are due at the time services are performed or products are ordered. As the patient/guarantor, you are financially responsible for any fees and costs associated with any services or products you receive from our office. This includes any medical service or visit, routine examination, testing, contact lens services and any other tests ordered by the doctor.

I understand and agree that it is my responsibility to know if my insurance has any deductible, copayment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive and I agree to make payment in full.

Co-payments will be collected at the time of service. Professional fees, services fees, copayments and deductibles are NOT refundable. There will be a $35 fee for returned checks.

I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance. Questions about insurance non-payment should be directed to your insurance company.

Referrals: As the patient/guarantor, it is your responsibility to know your insurance benefits and to provide our office with accurate and current insurance information. If your specific insurance plan requires a referral, it is your responsibility to obtain the referral from your primary care physician. If you arrive for an appointment without a referral on file, you have the option to reschedule the appointment or to pay in full for all services rendered.

I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full.

If I am a Medicare patient, I understand that I need to provide the office both my Medicare ID card and my secondary ID card. If the office does not have the proper information for a secondary insurance, the secondary will not be billed. It will be my responsibility to pay the balance and then file a claim with the secondary for reimbursement.

Our office does not write these policies. They are determined by your specific medical insurance or vision plan.

By signing here I acknowledge I have read and understand the Patient Insurance and Financial Responsibility statements.

_____
Printed Patient Name (and Guardian Name if applicable)

_____ _____
Patient or Guardian Signature Date