My Family Eyecare
820 Stateline Road
Colcord, OK 74338
918.422.5811

Patient Financial Responsibility Statement

Medical Insurance vs. Routine Vision Plans

Patients often have both medical and insurance and vision plans. Because they are very different in terms of the services and/or materials they cover, it is very important to us that you understand the differences.

Vision care plans (EyeMed, Superior, VSP, etc.) ONLY cover routine services. This means that if you have a "refractive error" without a medical condition and you simply need glasses or contacts to correct your vision, they may help you pay for your routine vision exam and the necessary materials. Most vision plans WILL NOT cover charges for medical issues we may encounter. If the examination today is to follow or treat a medical condition (macular degeneration, diabetes, glaucoma, dry eye, cataracts, etc.) your service today will be billed to your medical insurance as defined by the insurance carriers themselves. This is why we ask you for both vision and medical insurance coverage upon check in.

Please sign where indicated.

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Initials

To our patients without insurance:
Payment for all services rendered is due at the conclusion of the visit. If you are ordering any materials, our policy requires half of the amount due at the time we order your materials. The remaining half is due upon the dispensing of your glasses/contacts.

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Initials

To our patients with insurance: (Medical or Vision)
It is our pleasure to help you file your insurance claim forms or take assignment with your insurance benefits as designated by the plan of which you have indicated you are a member. **A "refraction" fee of $39 is not covered by most medical insurance**. If your visit results in a medical diagnosis and we bill your medical insurance, the $39 refraction fee will be your responsibility at checkout. You will also be responsible for all medical co-pays, deductibles or any non-covered service. If you have no medical diagnosis and we file your vision insurance, you are responsible for all co-pays and/or non-covered materials or fees. If any materials are ordered, our policy requires half of the amount due at the time we order the materials. The remaining half is due upon the dispensing of your glasses/contacts. **All** insurances for which the patient is a member must be stated and presented at the time of the visit and will not be accepted after services are rendered. If you have vision insurance and medical insurance, we will work to minimize your out of pocket expense by coordinating benefits between the two plans if allowed.

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Initials

To our patients who wear contacts:
We charge a higher fee for our contact lens exams as they require more information gathering and interpretation. Contacts lens wearers will also pay an additional contact

lens evaluation and training fee to cover the training involved for the daily use and maintenance of the lenses. This fee also covers the doctor's time to determine the lenses that will provide optimal vision and eye health. Experienced wearers may pay a lesser evaluation fee as training will not be necessary. In addition, fees will be determined by the type of lens required for both first time wearers and those experienced with contact lenses. **Some vision plans and most medical plans will not pay for this additional evaluation.** Thus, it will be your responsibility at check out. Once lenses are determined the day of the appointment and you have received the necessary training, we will have you return for a follow up appointment to make sure the lenses are working well and are healthy. If changes are required, our policy dictates that we will allow 2 more appointments (at no charge) within a 60 day period to fine tune or correct any issues.

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Initials

Financial responsibility:
In the event that your medical or vision plan denies payment for services or materials, you hereby agree to be financially responsible for any and all charges incurred by you or your child/dependent. In the event that any payments are not made, all finance fees, collection fees and attorney fees will be your responsibility as well.

Responsibility Statement for (name of patient) _____

Patient/Guardian **printed** name _____

_____ Date _____
Patient/Guardian **Signature**