Midwest Eye Care, P.C.

Comprehensive Medical vs Vision Screening

Patient Name: _____ Account Number: _____

You are being given this form because you may have both a medical plan and also a routine vision plan. To help better understand how your exam will be billed, please read the following sections and sign under the section that you feel best applies to your reason for services today.

1) Comprehensive Medical Exam:

Do you have, or have you been diagnosed with any medical eye condition(s)? Examples include:

- **Cataracts or history of cataract surgery**
- **Red, irritated, swollen eyes or eyelids**
- **Feeling like something is in the eye**
- **Floaters, Flashes of light**
- **History of retinal thinning or tearing**
- **Diabetes with Complications**
- **Macular Disease**
- **Headaches that require further workup**
- **Glaucoma or glaucoma suspect**
- **Moderate to Severe Dry Eye**

If so, a **Comprehensive Medical Exam** will need to be completed and billed to your medical insurance. You can still use your routine vision plan benefits for eyeglasses and/or contacts.

Medical Insurance Carrier: _____

Patient Signature: _____ Date: _____ Time: _____

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2) Routine Vision Evaluation

If **NO** known medical condition exists, a **Vision Evaluation for glasses and/or contact lenses** will be performed and submitted to your routine vision plan.

____ File a claim with my Routine Vision Plan: _____

or

____ I will pay the doctor exam self-pay fee today (the normal fee of $292 is discounted to $140, and reduced further to $125 if I have been seen in the last three years) in lieu of filing an insurance claim. Contact lens fitting exams will be an additional charge.

Patient Signature: _____ Date: _____ Time: _____

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3) Changing from a Routine Vision Evaluation to Comprehensive Medical Exam During Today's Visit

If a medical condition is found during today's **Routine Vision Evaluation** and the doctor determines that the medical issue needs to be addressed, a **Comprehensive Medical Exam** will be billed. By signing below, the patient agrees to a) have the medical issue(s) discussed today and b) have Midwest Eye Care bill his or her **Medical Insurance Plan** instead of the **Routine Vision Plan**.

Medical Insurance Carrier: _____

Patient Signature: _____ Date: _____ Time: _____