

# OUR PRACTICE POLICIES

2021-2022

We know patients have several options when choosing a vision care provider. We would like to express our sincere appreciation for having had the chance to be yours. We are committed to providing the best vision care possible and it is a pleasure to serve you. It is necessary that we inform you about your responsibility for the services we provide. Please do not hesitate to ask one of our staff members if you have any questions about our fees, policies, and/or your responsibilities. We can provide you with a copy of this document upon request.

Please carefully read sign below

## **PAYMENT FOR SERVICES AND MATERIALS:**

### **REFUNDS & CANCELLATIONS:**

Once an order has been placed for either contacts or glasses there are no refunds or cancellations. You are 100% financially liable for all purchases that have been made, even if your insurance neglects to pay. Glasses and contact lenses must be paid for in full, including any outstanding balances, prior to processing an order and picking up. Eyewear frame selections are final and cannot be changed. Eyeglasses and contact lenses that have not been picked up after 90 days from the first attempt we have made to notify you that products are ready for pick up will be donated to charity without a refund.

### **ELIGIBILITY & BENEFITS FOR MEDICAL INSURANCE AND/OR ROUTINE VISION:**

As a courtesy we will attempt to verify your plan eligibility for services and/or materials (glasses/contacts) to the best of our ability, but it is not a guarantee of payment. Please check with your plan administrator and or HR department if you have any questions regarding your benefits and eligibility. Our office does not participate in HMO major medical insurance plans, except Regal Medical Group, Central Health, and select Tricare plans.

### **FINANCIAL LIABILITY:**

If you have medical insurance or routine vision benefits, you authorize your plan carrier to directly pay the office of Dr. James Yoo O.D and Dr. Kim. You also authorize Dr. Yoo and Dr. Kim office to release any information required for payment to be made. *If your plan carrier does not pay or only partially pays in a timely manner (45 days from the time we have billed your insurance) you understand that you're responsible for payment in full of the remaining balance.* This may include any deductible, co-insurance, co-pays, and non-covered fees. If not paid in a timely manner, your account will be sent to collections and may be subject to interest and or late fees. My signature below verifies that I understand this agreement and that I am liable for any fee not paid by insurance benefits.

### **REFRACTION FEE:**

The part of your examination that determines your eyeglass prescription is called a 'refraction'. A refraction is also done under certain circumstances for diagnostic purposes. If you have routine vision benefits such as VSP, EyeMed, or Medical Eye Services, your refraction is typically included with your routine eye exam co-pay. Medical insurances that do not include routine vision benefits, such as Medicare, or 'Medi-Medi' do not cover the refraction. The fee for a refraction ranges between \$30-50 (fee determined by complexity). My signature below verifies that I understand the refraction if applicable.

### **CANCELLATION and MISSED APPOINTMENT POLICY:**

I understand that I will be charged \$50.00 per same day cancellation or "no-show" for each appointment in which I do not notify Dr. Yoo and Dr. Kim' office at least 24 hours in advance of the change.

### **PRIVACY POLICY:**

In the course of providing service to you we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, obtain payment for services, and to conduct healthcare operations involving our office. The Privacy Policy describes these uses and disclosures in detail and is available at the front desk upon request.

I acknowledge that I can obtain a copy of the Privacy Policy that are available at the front desk.

**I agree to the above policies.**

\_\_\_\_\_  
SIGNATURE OF PATIENT IF OVER 18 (Or Guardian if under 18)

Today's date: \_\_\_\_\_ Print patient name: \_\_\_\_\_

**CONTACT LENS evaluation exams and fees:** A contact lens prescription requires a contact lens exam with the doctor every year.

If you wear or want to wear contact lenses, you need a contact lens exam (evaluation) in addition to your comprehensive eye exam for glasses. An eye exam for glasses is not the same as a exam for contact lenses. A contact lens exam is necessary to ensure the lenses are fitting both eyes properly and that the health of the eyes is not harmed by the contact lenses. Dr. Yoo and Dr. Kim will perform certain tests and take measurements which may include measuring the surface of your eye to determine which size and type of contact is best, an evaluation of your vision with contacts, making sure your eyes produce enough tears to comfortably wear contacts. With the results of those tests, the doctor can provide a contact lens prescription that is the right fit for your eyes. An eyeglass prescription is not a substitute for a contact lens exam because the two are very different. An eyeglass prescription measures for lenses that are positioned approximately 12 millimeters from your eyes; whereas a contact lens prescription measures for lenses that sit directly on the surface of your eyes. An improper fitting of contact lenses can damage the health of the eyes. The eyes and what they need can change over time making it essential to check the fitting annually.

Contact lenses are medical devices that require a prescription. There are potential health risks that must be taken seriously. Contact lens prescriptions expire one year from the prescribed date. Fees for contact lens fitting & evaluation services **range between \$65 and \$200.00** ('Medically necessary contacts' for keratoconus, etc., require a more complex fitting and additional fees apply.) Fees are customized according to the complexity of the fit, patient's ocular health, eye history, and and the predicted time necessary to care for the individual patient. This fee does *not* include the contact lens supply. Contact lens fitting and evaluation fees are for time spent with the doctor and are non-refundable. My signature below represents that I understand the information described above and agree to the appropriate fees.

I agree to the contact lens policy.

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SIGNATURE OF PATIENT IF OVER 18 (Or Guardian if under 18)