

# PALMETTO EYE SPECIALISTS

## Payment and Insurance Policy

We are participating providers with **Medicare, Blue Cross Blue Shield PPO and Medicaid**. We will automatically file your claims to these insurers. You will be responsible for any applicable co-pays at the time of your visit. As a courtesy, we will also file claims to other primary insurers, however, payment in full for services rendered will be collected on the date of service. If you are a **Medicare** patient, we will file to a secondary insurer as well. Any tertiary policies or secondary policies to insurers other than **Medicare** are the patient's responsibility for reimbursement.

**Medicare**, as well as most other insurers, **DOES NOT** cover refraction charges. The refraction is a test that is necessary to determine one's best corrected vision and is an essential part of a complete eye exam. **THERE IS A \$35.00 CHARGE FOR THIS TEST WHICH YOU WILL BE REQUIRED TO PAY AT THE TIME OF YOUR VISIT.** Should you have any questions regarding this charge, please ask the medical assistant prior to the start of your exam.

Please acknowledge that you have **read** and **understand** our payment and insurance policy by signing below:

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

## Contact Lens Policy

If you are a current contact lens wearer or are considering contact lens for the first time, there is a **Contact Lens Evaluation fee yearly**. Fees may vary depending on contact lens type. This will be charged when the patient is fit with a trial pair of contact lens, to determine a new contact lens prescription or to update a current prescription. This fee is to be paid at the time the service is rendered as most insurers **DO NOT** cover the fitting fee.

**ALL CONTACT LENS PERSCRIPTIONS EXPIRE AFTER ONE YEAR FROM THE DATE OF EXAMINATION. THIS IS A FEDERAL REQUIREMENT AND WE ARE OBLIGATED TO ADHERE TO IT. If it has been a year since your last contact lens exam or fitting, you will need a new exam and fitting to update your contact lens prescription.** Should you have any questions regarding this charge, please ask the medical assistant prior to the start of your exam.

Please acknowledge that you have **read** and **understand** our contact lens policy by signing below:

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

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## Release of Medical Information and Assignment of Benefits

I hereby authorize the release of any medical information necessary to process my insurance claims and also assign to the physician all payments from Medicare, Blue Cross Blue Shield, Medicaid and any other insurance plan we may file on your behalf. I also give permission for any medical treatment deemed necessary by the physician.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

### **IF PATIENT IS A MINOR, A PARENT OR GUARDIAN SIGNATURE IS REQUIRED**

Patient Name \_\_\_\_\_ Relationship \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

