Maine Family Eye Care

Policies & Procedures

Patient Payment Responsibility: Most people have vision insurance and medical insurance. While they seem similar, they are very different regarding the services they cover and patients should be aware of and understand those differences. The below summary is intended to share a general summary of common benefit programs:

- Vision coverage plans (VSP, EyeMed, etc.) is usually filed to cover a routine prescription for glasses where medical or complex conditions don't exist.
- Medical coverage plans (Blue Cross Blue Shield, Medicare, MaineCare, Martin's Point, UHC, Aetna, etc.) is usually filed when a medical condition is present, such as diabetes, cataracts, dry eyes, floaters, trauma, foreign bodies, or other conditions.

Insurance carriers set various rules regarding how claims are filed, which type of coverage applies, and what procedures our office is required to follow that may change costs associated with your visit. We do our best to make sure you are aware of any out-of-pocket expenses, but there may be circumstances that arise during your examination or due to your insurance coverages that may result in changes.

Medical insurance will be used if you have a health condition related to the eye. This includes, but is not limited to, diabetic eye exams, hypertensive retinopathy, high risk medications that can affect the eyes, and other medically oriented circumstances. Factors such as these are not considered a "routine exam" and the Doctor will determine if conditions apply that are considered non-routine.

As a courtesy, we will bill your insurance plan for services if we are a participating provider for such plan. To file your insurance, our office requires your social security number. **If you do not provide this insurance information prior to your visit, we will not file insurance claims on your behalf and any costs will be considered "self-pay."**

Insurance Disclaimer: Verification of eligibility and/or benefit information is not a guarantee of payment. Quotes provided are an estimate of your out-of-pocket costs. Actual benefits will be determined once a claim is processed and based upon, among other factors, the member's eligibility. If your insurance does not cover all or part of your visit, you are responsible for any balances due.

Initial: _____

I understand and agree to the above-mentioned insurance and payment responsibilities, and I agree to have **Maine Family Eye Care** file insurance on my behalf. I am aware that I am responsible for any co-payments, deductibles or out-of-pocket expenses set in accordance with my insurance provider. I am also responsible for any treatment or testing that my insurance provider does not cover.

Returned Check Policy: Any check returned due to insufficient funds shall be charged a $30 service fee in addition to the value of the check.

Glasses Prescriptions and Contact Lens Policies: Glasses prescription follow ups are included in the cost of the exam for **3 months from the exam date.** After this period, a new exam is required.

A copy of your glasses and contact lens prescription will be available through your patient portal online.

Contact lenses are medical devices that require **annual** comprehensive vision and eye health evaluation before they are prescribed. In order to receive a contact lens prescription, you must have a yearly corneal and tear evaluation which is in addition to your eye examination. We will release your prescription to you after the doctor has determined that the contact lenses meet all the criteria for proper eye health and visual acuity specific to your case**.**

Visits on contact lens follow-ups are included in the cost of service for up to 60 days. After 60 days, there will be a charge of $99 for contact lens follow-ups. To be seen for a contact lens follow up, you must wear your lenses to your visit. Opened contact lens boxes cannot be returned or exchanged.

By signing this form, you are indicating that you have read, understand, and agree to the above information.

Printed Name: _____ **Date:** _____

Signature: _____

HIPAA Privacy Rights

HIPAA Privacy Act: This notice describes how medical information about you may be used and disclosed and how you may access this information. Please review the attached sheet carefully. A copy of this will be provided to you upon request. We safeguard information about your health in person. We collect information from you and store it in a computer-generated medical record. Charts are stored on the computer and are on the server only. Your charts are available only to designated staff and only for designated reasons. Housekeeping, maintenance and other non-personnel have no access to the chart or computer records. Service technicians may have access to computers, but only for services of computer operations. We may contact you regarding appointment reminders and we may provide you with information about health related or product benefits and services.

Patient Privacy Rights: You have the right to inspect and maintain a copy of medical information from your chart. Please note that this is only available in person and with a valid ID and with the signed medical release form. A copy of your visit can also be obtained online through your patient portal.

Policies: We are committed to offering the best and most thorough eye care possible. Please review our policies listed below as they are important to understanding the services offered at our office as well as how your payments are processed and how your insurance is billed.

I hereby affirm that I have received a copy of the *Notice of Privacy Practices* from Maine Family Eye Care. Under federal law 104-191, also known as HIPAA, I am entitled to receive a copy of this Notice from my healthcare provider. I understand that **my signature on this acknowledgement only signifies that I have received a copy** of the *notice* and does not legally bind or obligate me in any way. I understand that I am entitled to receive a copy of the *Notice of Privacy Practice* from my healthcare provider, whether I sign this acknowledgement or not.

Please note that if this form is filled out prior to your visit, a copy of our *Notice of Privacy Practices* is available on our website.

Printed Name: _____ **Date:** _____

Signature: _____

□ **Yes** □ **No** **Can we release information regarding your personal health records to the below? (HIPAA Privacy)**

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____