Greater Thumb Eyecare Policies & About Your Insurance

There are two types of health insurance that will help pay for your eye care services and products. You may have both and our practice may accept both:

1. Medical insurance (such as Blue Cross/Blue Shield and Medicare)

2. Vision care plans (such as VSP and EyeMed)

- Vision care plans only cover routine vision exams along with eyeglasses and contacts. Vision plans only cover a basic screening for eye disease. They **do not** cover **diagnosis**, management, or treatment of eye disease.

- Medical insurance must be used if you have any eye health problem or systemic health problem that has **ocular** complications. Your doctor will determine if these conditions apply to you, but some are determined by your case history. **If these conditions are present your exam(s) are considered a medical exam.**

- If you have both types of insurance plans it may be necessary for us to bill some services to one plan and other services to the other. **We are not responsible for the coordination of benefits between your insurers.**

- We will bill your insurance plan for services if we are a participating provider for that plan. We will try to obtain advance authorization for your insurance benefits so we can tell you what is covered. **If some fees are not paid by your plan, we will bill you for any unpaid deductibles, co-pays, or non-covered services as dictated by your insurance contract.**

- It is your responsibility to make sure that you have a referral from your primary care doctor if one is required.

1. Eyeglasses are a custom product and cannot be canceled or returned for a refund once your order is placed.

4. Balances outstanding for more than 30 days will incur a late fee of $5.00 per month. After 90 days, your account will be turned over to a collections agency and an additional fee of 45% will be assessed to your account.

1. 5. Glasses & lenses will be held for no longer than 180 days; any monies paid will be forfeited.

6. There will be a $35 fee for not keeping your scheduled appointment or for less than 24 hours' notice in canceling an appointment.

Authorization To Release Information And Pay Benefits to Physician:

I hereby authorize Greater Thumb Eyecare, PLC to release information to my insurance company that is acquired in the course of treatment, either verbally, in writing, or by fax. This authorization allows the release of information to another physician in the event it

becomes necessary to refer you to another physician. It allows the release of information to your primary care physician. I further hereby authorize my insurance company to pay directly to Greater Thumb Eyecare for any medical or vision benefits. I understand amounts deemed by my insurance company to be beyond what they may consider "usual, customary, and/or reasonable" charges for said services will be paid by me. I understand that I am fully responsible for any and all co-payment and deductible amounts. I understand that any service rendered to me that is not a benefit of my insurance company will be paid in full by me.

I have read and agree with these policies.

Patient signature (or representative) _____ Date: _____

Acknowledgment of Privacy Practices

I acknowledge that I was offered or received/reviewed a copy of Greater Thumb Eyecare's Notice of Privacy Practices. AKA the HIPAA Law.

Patient Name: _____

Signature: _____ Date: _____

Patient Authorization for Personal Representation

Patient Name

Purpose of request- I authorize Greater Thumb Eyecare, PLC to disclose or provide my protected health information to the following individuals who are authorized to act as my personal representative for the purpose of receiving all protected health information about myself. As my designated personal representative, they may exercise my right to inspect, copy, and correct my protected health information.

1._____ Relationship

2._____ Relationship

3._____ Relationship

Signature_____ Date

Authorization for Treatment of a Minor

I authorize the provider of Greater Thumb Eyecare to examine, diagnose, and treat the person listed below, for whom I am legally authorized to give consent. I authorize such services that the provider feels are necessary or advisable and are rendered under the provider's general or specific instructions.

Patient Name _____ DOB

Parent/Legal Guardian Name_____ Relationship

Parent/Legal Guardian Signature_____ Date