The Midwest Center for Sight
Office and Financial Policies

Dear Patient,

We find it necessary to explain some terms pertaining to payment for health care and policies in our practice.

MEDICAL & ROUTINE EXAMS: The doctors are board certified medical doctors. We will always file a medical diagnosis to the insurance company if you have a medical diagnosis. Without a medical diagnosis we will file myopia, hyperopia or presbyopia. These are considered refractive diagnosis. Most insurance companies will not pay for a refractive diagnosis; therefore the patient will be responsible for the exam. However there are some insurance companies that do cover a routine refractive eye exam. If your insurance company does cover a routine exam please advise us as we will bill the refractive diagnosis over the medical diagnosis.

Refraction: One of the most important parts of your eye exam today is the refraction. This is the part of the exam which we determine whether you can be helped in any way by a new glasses prescription. It is also how we determine the best possible visual acuity and function of your eye, which is essential medical information for us to have as we assess your eyes and look for problems. It is **NOT** a covered service by Medicare and many other insurance plans. These plans consider refraction a "vision" service not a "medical" service. Our office fee for refraction is **$55.00** and unless your plan automatically covers the refraction charge, this fee is collected at the time of service. Should your plan pay us for the refraction, we will reimburse you accordingly. I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service and understand it is due at time of service.

DILATION: Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside back of your eye. As with many medications, there are some side effects of the drops used to dilate the pupil. These effects include light sensitivity and blurred vision up close, (reading fine print). In most cases distance vision will not be affected. Dilation may also affect your ability to drive or operate machinery safely. You will be offered disposable sunglasses at the end of your exam to help with the light sensitivity. If you do not feel comfortable driving or walking on your own, please have someone accompany you to your visits.

Prescription Refills: Refills will only be given during regular office hours.

Phone Calls: The office will return phone calls in order of urgency. All calls will be returned within 24 hours.

DRIVERS LICENSE FORMS: If you have failed your driver's test and are required to have the form filled out for the Secretary of State, you will be required to have a visual field test done. There is a **$95.00** charge for the test and is not billed to the insurance company. The physician will review the results of the test, fill out the form and mail it to the patient within 5 days. If the physician feels that the results of the test does not meet the requirements of the Illinois Secretary of State, we will contact you.

CHART COPYING: If you need a copy of your chart, please fill out a formal request and allow 5 business days for your copy. There is a copying fee based on the number of pages. Our medical records department will advise you of the charges.

NO SHOW OR LATE CANCELLATION: If you are unable to keep your appointment kindly give us 24 hour notice. There will be a nominal fee for a late cancellation or for not showing up for your appointment. Exceptions will be made for true emergencies.

Turn Page Over

INSURANCE: Please bring your insurance card with you to each visit. As a courtesy to you, we will file your claim to your insurance company. However if after a 60 day period we have not received payment, the bill becomes the patient's responsibility. It is up to you to contact your insurance company at that point to resolve the payment issue. If you have an HMO insurance please bring your referral with you. If you do not have a referral, we will need to reschedule your appointment.

Medicare No Secondary Insurance: Patient is responsible for the 20% not covered by Medicare at time of service.

Medical Insurance and Vision Plans: We are a medical practice and will file on your behalf to your medical plan. If you do not have a medical diagnosis it is likely the visit will not be covered under your medical plan. We do participate in a vision service plan VSP.

Co-pays/Deductibles: These are fees that are agreed upon by you and your insurance company. When a co-pay or deductible applies you will be expected to pay that amount at time of service. **A $10.00 billing fee will be added for all co-pays/deductibles not paid at time of service.**

Financial Assignment and Agreement:

1) Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance. A late fee of $25.00 will be added monthly until balance is paid in full. In the event your account is turned over to our collection agency, you will be responsible for the balance on your account plus the service charges for the collection agency.**

2) I request that payment of authorized Medicare and or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.

3) This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. **I understand that I am financially responsible for all charges whether or not paid by said insurance**. I hereby authorize said assignee to release all information necessary to secure the payment.

X_____ _____

Patient Signature/Parent or Guardian if minor **Date**