INSURANCE BENEFITS

Lakeway Eye Physicians and Surgeons (LEPS) will file claims with your insurance carrier as a courtesy to you.

Ultimately, please understand, your insurance contract exists between you and your insurance carrier. We will attempt to verify benefits and coverage prior to your visit, however, as per all insurance contracts, there is no guarantee that payment will be made for services rendered. You are ultimately responsible for any fees incurred. **All co-insurances, co-payments and deductibles that have not been met will be collected at the time of service**.

Fees for routine vision tests including refraction* and contact lens exams are not typically covered by medical insurance and will be collected at the time of service. (*refraction is the test required to write a prescription for eyeglasses). Should services be paid by your insurance, your account will be credited.

Should your insurance require a referral from your Primary Care Physician, it is your responsibility to **obtain the referral prior to the appointment date.**

Contact lenses, contact lens fitting, and refraction* are elective services and are generally not covered by medical insurance. **Fees for these services will be collected at the time of service**. Refraction as a non-covered expense is $50.

Note: While seeing the Optometrist under your Vision Care Plan benefits, should a medical diagnosis be discovered, the exam may be billed to your medical insurance rather than to Vision Care.

_____ ***Patient/Guarantor initials***

FINANCIAL POLICY

I understand that I am fully responsible for any and all charges incurred. I further understand that all payments and co-payments are expected at the time of service. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize and direct my insurance carrier(s), Medicare, private insurance, and any other health/medical plan, to issue payment check(s) to Lakeway Eye Physicians and Surgeons (LEPS) for medical services rendered to myself or my minor children regardless of my insurance benefits, if any. **I understand that I am responsible for any amount not covered by insurance**, If I need a consent or referral from my Primary Care Physician and have not obtained one, I understand I am financially responsible for charges incurred at the time of service. I understand that if my account is delinquent and is turned over to a collection agency, I will be responsible for all collection costs. If I choose to pay by check and my check is dishonored, I agree to pay a processing fee of $30, or any higher amount allowed by law, and LEPS may electronically debit or draft my account for this fee. Also, if my check is returned for insufficient or uncollected funds, my check may be electronically re-presented for payment.

Cancellation Policy: Please be advised that missed appointments or cancellations with less than 24 hours' notice may be subject to a $50 cancellation fee.

I hereby authorize Lakeway Eye Physicians and Surgeons to: (i) release any information necessary to insurance carriers regarding my treatments (ii) process insurance claims generated in the course of examination and (iii) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

_____ _____

Patient/Guarantor SIGNATURE ***Date***