



KEEPING YOU IN SIGHT

**FINANCIAL RESPONSIBILITY:**

Payment for all professional services rendered is due at the time of service. If you have health insurance, it is your responsibility to ensure we have the correct and current information for your insurance plan. It is also your responsibility to pay the copay at the time of service per our contract with your insurance plan. If you are not using health insurance, Johnson EyeCare offers a self-pay discounted fee schedule. Payment for services rendered is required at the time of service.

---

Signature of Patient/Responsible Party

Date

**ASSIGNMENT OF BENEFITS:**

I hereby assign all medical benefits, to include major medical benefits, to which I am entitled, to Johnson EyeCare for services rendered. I hereby authorize and direct my insurance carrier (including Medicare, private insurance and any other vision or medical plan) to issue payment(s) directly to Johnson EyeCare for health care services provided to me and/or my dependents regardless of my insurance benefits, if any. I understand that I am financially responsible for copay, coinsurance and deductible at the time of service and for any services rendered that are determined to be “non-covered services” by my plan. I certify that the insurance information I have provided to Johnson EyeCare is true and that it is my obligation to know my plan’s requirements and ensure that they have been fulfilled. **I understand that my insurance(s) may not pay 100% of the amount of the claim for services rendered and that I am responsible for any and all amounts not payable by my insurance(s) that are assigned to me.** I agree to notify Johnsons EyeCare of any changes in the information I have provided. This assignment of benefits will remain in effect until revoked by me in writing to Johnsons EyeCare.

---

Signature of Patient/Responsible Party

Date

**NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGMENT**

We keep a record of the health care services we provide to you. You may request a copy of your medical record in writing. We will not disclose your record to others unless you direct us to do so or unless legal authorities authorize or compel us to do so. You may request a copy of your medical record or get more information by contacting the Johnson EyeCare Clinical Privacy Officer. Our notice of privacy practices is available at the reception desk and is posted in the clinic. The Notice describes in greater detail how your health information may be used or disclosed, and how you can access your information. You are entitled to a copy of this Notice and it is available at your request.

I acknowledge the Notice of Privacy Practices has been offered to me and is readily available in accordance with the Health Insurance Portability and Accountability Act.

---

Signature of Patient/Responsible Party

Date

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION:**

I authorize the release of medical information regarding myself/my dependents and my current condition my referring, consulting, or treating physicians.

---

Signature of Patient/Responsibility Party

Date



KEEPING YOU IN SIGHT

It is important that you are aware of your insurance and vision plan benefits and how they apply to your visit. We have prepared this sheet to help you understand how your visit is submitted to your health insurance plan and/or vision plan for today’s visit. **If you have any questions about your coverage at our office, you should contact your plan directly for a quotation of benefits. You are responsible for any fees incurred at our office that your vision plan or insurance plan does not cover.**

**VISION PLANS vs MEDICAL INSURANCE**

If you are using a vision/discount plan for your visit today, please be aware that your vision plan will cover an eye exam for glasses and an eye health screening ONLY. **If your doctor finds a medical problem with your eyes during the visit, your vision plan may not cover the visit, and your medical benefits will apply.**

**PREVENTATIVE EYE CARE vs MEDICAL EYE CARE**

**Benefits (and therefore the fees you may owe) will vary based upon the reason for your visit. Most insurance plans have different benefits for “ROUTINE EXAMS” vs. “MEDICAL EXAMS.”**

**ROUTINE EYE EXAMS:** Your vision plan covers “routine” care only. Your plan defines “routine care” as a comprehensive eye examination when you do not have any medical condition affecting the eye(s). Your doctor will perform a thorough exam to include updating your glasses prescription, and an eye health exam. Contact lenses services are considered “elective”, and additional fees may apply.

**MEDICAL EYE EXAMS:** Annual comprehensive eye examinations that result in a medical diagnosis or visits outside of the annual exam to monitor/evaluate/treat medical conditions related to the eye will result in a claim being sent to your medical insurance.

Examples that will necessitate your visit being submitted as a medical exam include but are not limited to:

- Annual diabetic exam\*
- Referrals from outside physicians
- Use of high-risk medication (Plaquenil, steroids, etc.)
- Complications of related to contact lens wear
- Macular degeneration
- Visits that result in a prescription for medication
- Glaucoma
- Eye Irritation (red eyes, eye pain)
- Eye muscle imbalance
- Dryness or itchy eyes
- Allergies
- Floaters and/ or flashes of light

**\*Please note that if you have diabetes, the visit must be coded as a “medical eye examination” and a claim will be sent to your medical plan. If you have diabetes benefits through a vision plan, we will coordinate benefits.**

**The findings during the visit will determine which insurance benefit will be used.** If your doctor determines that the visit relates to a medical problem, your visit may be billed as a medical exam instead of a routine vision exam, which will be subject to co-pays and deductibles according to your medical insurance plan. We will submit separate claim to your vision plan for the refraction (evaluation for glasses prescription) when applicable.

Print Name

Signature

Date