❑ J. Britt Wright, OD
Therapuetic Optometrist
Optometric Glaucoma Specialist

❑ Stephen G. Slade, MD
Surgical Director

INSURANCE POLICIES

Medical Insurance – Medicare, United Health Care, Blue Cross, Aetna, Cigna, etc.

We bill medical insurance when you present a medical related complaint such as: itch, burn, dryness, redness, eye pain, etc. that may or may not require treatment and monitoring. We will also bill your medical insurance carrier for medical diagnosis/findings such as **Diabetes, Glaucoma, Cataracts, Floaters, Macular Degeneration, etc.**

- **HMO Policies:** If an authorization/referral for your visit cannot be obtained, you will be billed for the services redered.
- **If you present with both a vision complaint and a medical complaint, we will bill to the appropriate insurance as indicated in your insurance by-laws.**

Medicare and Medicare Advantage Plans

We are Medicare participating providers; therefore, we will bill Medicare directly. However, as with any insurance carrier, you will be responsible at the time of services for payment of:

- The annual deductible: **$240.00**
- Co-payments/Coinsurance: **20%** of allowable procedures if deductible not met.
- Charges for non-covered services: Example: **$45.00 Refraction fee** (may not be covered by Medicare supplement plan and/or vision discount plan).
- Refraction is required to determine your best corrected vision. We will conduct refraction whether you wear glasses or not.

You will also be asked to sign an Advanced Beneficiary Notice (ABN) form in the event a service is provided, which we know is not covered by Medicare or your supplemental insurance.

Vision/Routine Insurance – VSP, Superior, Eyemed, Spectera, etc.

These discount plans are billed for routine eye exams, glasses or contacts lenses. They do not cover medical related complaints or conditions.

Optomap Retinal Digital Photos – Medical and Routine Imaging

Medical Findings will be billed to your medical insurance. Routine imaging will be discounted to $25.00 unless covered by your vision plan.

- A view of the retina, giving Dr. Wright a more detailed view in lieu of dilation in most cases.
- A permanent record for your file, which allows Dr. Wright to view your images each year to look for changes.

Vision Insurance: ______________________ ID# ______________ Group# ________________

Primary Medical Insurance: ______________________ ID# ______________ Group# ________________

Secondary Medical Insurance: ______________________ ID# ______________ Group# ________________

GUARANTOR (POLICY HOLDER) ❑ Self ❑ Spouse ❑ Parent

(If you are the patient and the Primary on the insurance you do not need to complete this portion.)

Last Name: ______________________ First Name/MI: ______________________ Suffix:_______

Gender: ____________ DOB: ______________ SSN: ______________________

Address: ______________________ Home Phone: ______________________

City: ______________________ Cell Phone: ______________________

State: __________ Zip: ______________ Employer: ______________________

ASSIGNMENT OF BENEFITS AUTHORIZATION

I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such eye care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the eye doctor or ophthalmic group insurance benefits otherwise payable to me - I understand that my eyecare insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf and that of my dependents.

CONSENT FOR TREATMENT

I hereby authorize Wright Eye Care Center to examine and treat me, or, the individual for whom I am responsible. During the course of exam, dilation drops may be used to dilate the pupils. These drops may cause temporary blurred vision and glare.

X____

SIGNATURE OF PATIENT *(Or parent if minor)* DATE