WRIGHT
EYE CARE CENTER

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wrighteye2020.com

CONSENT AND POLICIES

Thank you for choosing Wright Eye Care Center for your eye health needs. We would like to take this moment to discuss our financial policies and consents.

At the end of this document please acknowledge that you have read, agreed and consented to the following.

While providing health care to you, we may need to create, receive, and/or store health information that potentially identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for services, and to conduct healthcare operations involving our office. A comprehensive "Notice of Privacy Practices" is available from our office that describes in detail the use and disclosure of such health information. You are free to refer to this notice at any time before you sign this consent document. As described in our "Notice of Privacy Practices" the use and disclosure of your health information is necessary for you to receive ongoing care from this office or in conjunction with other health professionals. Our "Notice of Privacy Practices" will be updated when our privacy practices changes. Whenever our practices change you may obtain an updated copy from our offices, or from our website at www.wrighteyecarecenter.com. When you sign this consent form, you agree to the use and disclosure of your health information to treat you, to obtain payment for our services, and to perform healthcare operations.

Insurance Consent – I hereby consent to the release of medical information (self, child/dependent, or family member) to the insurance companies responsible for my care. I understand that while my medical records are confidential, information within these records may be required by my insurance company in order to facilitate care, and will only be released at their request. I understand that by signing this consent form, I am allowing my medical information to be released upon my insurance company's request, for the purpose of healthcare operations (including but not limited to, provider review function, claims payments, and quality assessment).

Insurance Services – Wright Eye Care Center is in network as preferred providers with many medical health plans and vision discount plans. Wright Eye Care Center will make every effort to verify coverage and benefits prior to your visit with the physician. **If we are unable to verify benefits, we will ask you to pay in full or reschedule your visit until the verification can be obtained.** This verification will be used to estimate your financial responsibility; however, this verification is not a guarantee by your health plan of coverage or payment. If your health plan denies any part (or the entirety of your claim), you agree that you are financially responsible for the balance.

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:** We will help assist you in obtaining a referral authorization from your **Primary Care Physician (PCP)** by faxing the detailed information required for your visit. If we cannot obtain an authorization/referral for your visit, you will be billed for the services rendered. **Reminder:** If you have not established care with your designated **Primary Care Physician (PCP)** for your HMO medical insurance, you may be required to schedule an appointment with your Primary Care Physician (PCP) prior to authorizing referrals. Primary Care Physicians (PCP) may have their own policies in place to issue referrals for services.
• 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.

Optomap Retinal Digital Photos: Medical and Routine Imaging:
Medical Findings will be billed to your medical insurance. Routine Imaging will be discounted to $30.00 unless covered by your vision plan.

- Optomap Retinal Imaging is a view of the retina, providing our doctors a more detailed view in lieu of dilation in most cases.
- A permanent record for your file, which provides our doctors to view your images each year to look for changes and make comparisons.

Medicare Notice – 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 deductibles
- Co-payments
- Charges for non-covered services: Example: $45.00 Refraction fee (may not be covered by Medicare supplement plan and/or vision discount plan). A 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.

Important: Please let us know if you signed up for a Medicare Advantage Plan. Traditional Medicare and Medicare Advantage Plans are not the same. If you signed up with a Medicare Advantage Plan, you no longer have traditional Medicare.

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. Most vision discount plans require an authorization before your services is rendered. If we cannot obtain an authorization, you will be responsible to pay for both professional services as well as eye wear materials.

Private Pay Patients – We will provide you with itemized receipts for all transactions if you chose to file your own claim to your insurance carrier.

Contact Lens Policy – (only applicable for patients desiring contact lenses) All contact lenses are "medical devices" according to federal law, and as such, require a proper fitting (in addition to the routine examination) to ensure ocular health. For patients who would like to be fit with contact lenses, the doctor performs a comprehensive eye exam to check the overall health of your eyes, as well as additional testing to assess the fit, prescription, and type of contact lens that best suits your eyes. **The contact lens fitting fee ranges from $79.00 on up depending on the complexity of your prescription needs.** This fee includes trial contact lenses for the purpose of prescription changes and follow-up visit(s) when needed. Fees that are paid for examinations, contact lens evaluation/fitting, and progress checks for contacts lenses are non-refundable. **If you are brand new to contacts, a one-time fee of $25.00 is charged for a Contact Lens Training in our office.** A period of 60 days is allotted for all contact lens follow-up visits. A separate charge for any additional visits past the 60-day time frame may apply. Your prescription will be finalized once the doctor has determined an appropriate and healthy lens that you are satisfied with, and you have expressed to us that you would like to proceed with an order. **Contact Lens Exams are required annually along with a Comprehensive Eye Exam. A contact lens prescription is valid for 1 year.**

Payment – Payment of copays, deductibles, coinsurance, out of pocket or non-covered services are due upon check out. We always obtain the most accurate amounts due from your insurance carrier. We will issue a refund or bill your account once we receive your explanation of benefits (EOB) from your insurance carrier. You will receive a detailed statement in the mail regarding your portion of the bill.

Payment Methods – For your convenience we accept cash, pre-printed NON temporary checks, Visa, MasterCard, American Express, Care Credit, Discover, Flex Spending/HSA accounts and online bill pay as a form of payment.

Claim Denials – Please be aware that certain office products, procedures or services may not be covered, or may be considered not medically necessary by your health plan. You are responsible for payment of these services. Such procedures and products include but are not limited to contact lens fittings, specialty contact lenses, specialty eye glass lenses and designer frames, glaucoma scans, visual fields or other medically necessary testing. You will be billed if we obtain a denial from your insurance company and/or we have not received payment from the insurance company within 60 days of
our filing your claim.

Past Due Accounts – If your account becomes past due, we will take necessary steps to collect this debt. We are here to help.

We encourage you to contact our insurance billing specialist/manager to discuss your bill as needed.

Christina Edwards-Hall, Insurance and Billing Manager
Phone: 936-297-2031
Fax: 281-362-5764
Email: Christinaedwards-hall@wrighteye2020.com

- Our insurance manager is available Monday-Friday 8:30-3:00pm. If Christina is unavailable to take your call, please leave a detailed message and she will return your call within the next business day.

NSF Checks – There will be a $25 service fee charged to your account if your check is returned by your bank for any reason. Upon notification from our office of your returned check, payment of the entire balance is due immediately. We will accept payment in the form of credit card, cash, or money order.

Photo & Social Media – Wright Eye Care Center uses a variety of resources to publicize events, products, and services. Should you **object** to a photograph or other electronic image of you or your child on social media, the company website, marketing brochures, publications, newsletters, or other media coverage prepared for use both inside and/or outside Wright Eye Care Center, please notify our office. We would love for you to share your experiences at Wright Eye Care Center with your family and friends!

☐ * I have read and agree to policies and consents outlined above (required)

Patient Signature____ Date_______________