Examination and Fees notice:

VISION AND MEDICAL BENEFITS:

As NWECP is a specialty clinic, there are more opportunities that a medical eye examination will be performed in lieu of a standard routine eye examination. For insurance purposes, eye examinations are broken into two categories; Medical & Routine. Routine eye examination benefits cannot be applied to a medical carrier and in most instances medical eye examinations cannot be applied to a routine carrier. If you have been referred to NWECP for a comprehensive evaluation, especially for a therapy consult, you will most likely be provided a medical eye examination. Understanding the difference between the two types of examinations and your carriers will help you complete a financial plan for your visit.

*Vison Service Plan (VSP) members: In some cases, Vision Service Plans (VSP) will accept a medical claim. VSP members that have a refraction during today's visit, are eligible for your routine eye exam benefit, and meet all other requirements (as deemed by VSP), VSP may pick up a portion of your medical visit AFTER your health plan has processed. In order to use both of your benefits for today's visit, please let our office staff know your intentions. They will provide you with the form needed for *you* to submit for secondary benefits.

Medical Eye Examination that includes a refraction:

This evaluation will include an assessment for medical conditions related to the eyes, including, but not limited to: TBI's (traumatic brain injuries), ABI's (acquired brain injuries), neurological diseases, developmental conditions, glaucoma, macular degeneration, cataracts, dry eye syndrome, corneal disorders, double vision, infections, diabetic retinopathy, injuries, foreign bodies, etc. **ALL** Medical examinations are billed to your medical carrier regardless that you have private routine insurance. These fees could be applied to a deductible, or you could have a co-pay or co-insurance. **Please Note:** All of the out of pocket expenses are due at the time of service.

Routine Vision Examination:

A vision examination includes a general *screening* for eye disease and a refraction. (A refraction is a service that is provided to obtain the measurement of a prescription for glasses.) These types of examinations **DO NOT** include an evaluation or treatment of any medical conditions.

I understand the difference between a Medical Eye Examination and a Vision/Routine Exam _____ initial

CONTACT LENSES:

Additional testing is required for the evaluation and management of contact lenses. Due to this requirement of additional evaluation above a routine eye examination, there will be an additional fee. Contact lens fittings are required on all new **and** established patients. Fees will vary based upon the evaluation needed as well as the type of contact lenses prescribed. The fee range can be $50.00-$200.00. There are a few vision carriers that will reimburse for these fees when billed with an eye exam.

I understand that additional fees apply to contact lens services _____ initial

REFRACTION FEE:

A refraction is a required measurement used to determine the amount of prescription needed to correct your vision, if any. Glasses may be prescribed from the refraction provided. Most medical insurances will **NOT** pay for refractions. You will be required to pay the $50.00 refraction at the time of service. If there is a chance that your carrier may reimburse, we will bill it for you.

I understand that refractions are not covered by most medical carriers _____ ***initial***

I have read all of the information above and understand that my services will be billed to the appropriate insurance provided based upon the information outlined in this document. I understand that additional fees apply for contact lens and refraction services, if they are performed. **(Signing the understanding of the policy does not dedicate a patient to services such as the contact lens fitting.)** I assume responsibility for any fees that are not covered by my insurance carrier.

Patient Name: _____

Signature: _____ Date: ___/____/_____

Printed Name: _____

Relationship to the Insured: Self Guardian Power of Attorney