Routine vs. Medical Eye Exams

Your vision and the health of your eyes are very important. Eye disease can occur without any symptoms at all, and because of this Lake Ridge Vision Source recommends regularly scheduled eye exams for **ALL** of our patients.

Healthy eyes require a Routine Vision Exam (Annual preventive Exam) every year. This exam will screen for eye disease and provide measurements for glasses and/or contact lenses.

Lake Ridge Vision Source is contracted with only certain vision plans for a Routine Eye Exam. Routine eye exams are defined as a “regular check-up” for patients in need of glasses/contacts. If the chief complaint or primary reason for today’s visit is, **dry eyes, diabetes, floaters, cataracts, burning, or itching of the eye, (etc)** will become a MEDICAL eye exam and will be submitted to the MEDICAL insurance.

**Today you are here for: (Please initial one choice)**

- [ ] Routine/Annual Preventative Eye Exam
  - **Reason for a Routine/Annual Preventive Eye Exam**
    - Myopia (Nearsighted) • Presbyopia (Bifocal age)
    - Hyperopia (farsighted) • Astigmatism

- [ ] Medical Eye Exam
  - Exam will be billed to medical insurance
  - My portion is my specialist copay and $45 refraction fee.
  - **Reasons for a Medical Eye Exam**
    - Diabetes ■ Dry Eyes ■ Sudden Loss of Vision
    - Glaucoma ■ Iritis ■ Floaters/ flashes of light
    - Cataracts ■ Macular Degeneration ■ Painful Eye

**Initals**

**Refraction Policy**

1. **Refraction** is the measurement of the lens power necessary to prescribe or change your glasses and/or other corrective lenses. A contact prescription CANNOT be given without a current glasses prescription. Refraction may also be done for diagnostic purposes.

2. Most medical insurance plans, including MEDICARE, do not cover the refraction fee. If your examination includes a refraction, and your insurance does not cover this, there will be a $45.00 charge,
Insurance Agreement

____1. Lake Ridge does not bill in office, we outsource to an optometry billing company. Please provide the front desk ALL COPIES of medical and vision insurance cards. Our billing company will bill to all primary and secondary insurance if necessary. If any balances are due, you will receive a bill from the office.

____2. Some insurance companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is the patients responsibility to pay any deductible, co-insurance, and/or other balances not paid by their insurance. If your account is overdue, you will be responsible for any collection fees and costs. There is a late penalty fee of $25 dollars that will be added to the account after 3 months overdue.

   *There will be a $35 reprocessing fee if the correct insurance is not given at the time of visit*

____3. Be sure to bring and present any referrals as required by your insurance company for your appointment. If you do not have a referral you may have to reschedule your appointment or pay in full at the time of your visit.

Patient Financial Responsibilities

____1. All co-pays, balances, orders of eye glasses, and/or orders of contacts must be paid in full at the end of your visit. We accept personal check, cash, or credit/debit card. NO GLASSES OR CONTACT ORDERS WILL BE PLACED UNTIL ALL PAYMENTS ARE MADE.

At Lake Ridge Vision Source, you can expect to receive medical services in a caring and professional manner. We request that you keep scheduled appointments and arrive at the appointment time. If you are unable to keep your appointment, please give at least a 24-hour notice. Same day cancellations or a no show to the appointment will result in a $50 fee per patient.

For patients without insurance, or whose insurance we do not take are considered “SELF PAY” patients. To self-pay for the comprehensive exam is $110 and the refraction charge is $45 equaling a total of $155. Lake Ridge offers a “self-pay” discount of $20, leaving the patient with a $135 charge for the appointment. This charge is due at the time of the appointment.

All the staff at Lake Ridge Vision Source appreciates your confidence in allowing us to participate in your eye care. Your signature indicates that you have read, understand, and agree to all the policies and procedures of our Practice.

Please sign: ____________________________  Print Name: ____________________________

Date: __________