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) may result in a MEDICAL diagnosis

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 (Please provide PCP information to help us better coordinate your care)

- Exam will be billed to medical insurance
- My portion is my specialist copay and $55 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

Refraction Policy:

Only Initial if having a MEDICAL eye exam, self-pay, or have Medicare as primary Insurance

1. All 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 $55.00 charge.

2. 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.
Please Provide your Primary Care Physician’s Information to help us better coordinate your care:

Dr. Name: ___________________________ Office Name & Number: __________________________

Please Provide your preferred pharmacy so the office can properly send prescriptions.

Name: ___________________________ Location: ________________________

Phone Number: _______________________

HIPPA Agreement (form can be found at front desk)

“I have read the terms and conditions of the HIPAA consent form, and..”
I Agree □ I DO NOT Agree □

Financial Agreement

• 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
  o There is a $35 reprocessing fee if the correct insurance is not given at the time of your appointment.
• Some insurance companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is the patient's responsibility to pay any deductible, co-insurance, and/or balances not paid by their insurance.
  o If your account is overdue, you will be responsible for any collection fees and costs.
  o There is a late penalty fee of $25 dollars for ANY account overdue of 90 days.
• Lake Ridge Vision Source is not required to obtain any referrals required by your insurance. If you require a referral and do not obtain one for your appointment, you will be held liable for any charges.
• 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.
• Lake Ridge Vision Source cannot release any patient information without the consent of that patient. If you would like the office to release any information to another provider or person, please ask the front desk for a Records Release Form. If a patient is over 18 and would like a parent or other family member to have access to their records, please ask the front desk for a Release of Information form.
• 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.

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: _____________