Mercy Eye Care

PAYMENT IS REQUIRED AT TIME OF SERVICE. IF YOU DO NOT HAVE YOUR COPAY PLEASE SEE THE RECEPTIONIST TO RESCHEDULE YOUR APPOINTMENT.

_____I understand the charges for services listed below and I understand that payment is required on date of service. I understand that a 50% deposit is required for any products ordered.

EXAM FEES

The fee for a refraction (determining your prescription for corrective eyewear) is separate from the fee for the routine eye health exam. A refraction charge is $30 and is not covered by some insurance plans including Medicare.

_____I have been informed and I understand the charges for the refraction and that I am responsible for this fee.

The fee for a contact lens evaluation is separate from the fee for the routine eye health exam. This fee ranges from $30-$150 depending on the type of lenses you require and whether you are an existing contact lens patient. Your insurance plan may or may not cover this fee.

_____I have been informed of the contact lens evaluation fee policy and I understand that I am responsible for this fee.

RELEASE OF INFORMATION

_____I hereby authorize Mercy Eye Care to release any information acquired in the course of my examination and/or glasses/contact lens transaction to my insurance carrier or vision plan or party that is or may be liable for all or part of my charges. Only such diagnostic and therapeutic information as may be necessary to determine benefit entitlements and to process claims for health and vision services to the above named patient shall be released. This authorization shall be valid only for the period necessary to actually process claims pertaining to the patient.

ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY

_____I hereby authorize my vision plan or insurance plan benefits to be paid directly to Mercy Eye Care. I understand that I am financially responsible for non-covered product and services as well as deductibles, coinsurance, or amounts in excess of insurance benefits.

PATIENT'S RIGHTS AND RESPONSIBILITIES

_____I have received a copy of and understand my rights and responsibilities under the Health Insurance Portability and Accountability Act (HIPAA).

_____ _____

Signature of Patient Date

_____ _____

Signature of Guarantor Date