

**KELLER EYE CARE MEDICAL/VISION SERVICES FINANCIAL POLICY**

I HEREBY AUTHORIZE AND CONSENT TO VISION/MEDICAL TREATMENT BY JARROD R. KELLER, OD, FOR ME (OR MY CHILD). I AUTHORIZE KELLER EYE CARE TO RELEASE MY (OR MY CHILD'S) MEDICAL OR VISION INFORMATION TO MY (OR MY CHILD'S) FAMILY PHYSICIAN OR TO OUR INSURANCE COMPANY, IF REQUESTED.

I AUTHORIZE KELLER EYE CARE TO REQUEST PRIOR TREATMENT RECORDS FROM \_\_\_\_\_ TO AID IN MY (OR MY CHILD'S) TOTAL OCULAR CARE/TREATMENT. THIS RELEASE WILL REMAIN IN EFFECT FOR 2 (TWO) YEARS.

SIGNED: \_\_\_\_\_

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR PAYMENT FOR ALL MEDICAL/VISION TREATMENT RENDERED TO ME (OR MY CHILD) BY KELLER EYE CARE, AND AGREE TO PAY ALL CO-PAYMENTS, DEDUCTIBLES, AND NON-COVERED SERVICES IN FULL AT THE TIME OF SERVICE. ALL PAST DUE BALANCES MUST BE PAID IN FULL PRIOR TO APPOINTMENT. IN THE EVENT THAT A REFERRAL IS REQUIRED BY MY INSURANCE FOR A SPECIALIST, I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO OBTAIN SUCH REFERRAL, PRIOR TO MY APPOINTMENT.

I UNDERSTAND THAT MY PART OF ALL MATERIALS MUST BE PAID IN FULL BEFORE ORDERS WILL BE PLACED. I ALSO UNDERSTAND THAT KELLER EYE CARE, AS A COURTESY TO ME, WILL SUBMIT A CLAIM TO MY INSURANCE CARRIER, AND I AUTHORIZE PAYMENT DIRECTLY TO KELLER EYE CARE FOR THE BENEFITS OTHERWISE PAYABLE TO ME UNDER THE TERMS OF MY CONTRACT. IF USING INSURANCE BENEFITS, I UNDERSTAND THAT A CURRENT INSURANCE CARD MUST BE PRESENTED AT EACH VISIT, ALONG WITH A PICTURE ID TO VERIFY IDENTITY, OR MY VISIT WILL BE CONSIDERED "SELF PAY". IT IS MY RESPONSIBILITY TO MAINTAIN CURRENT COVERAGE INFORMATION TO MEET FILING DEADLINES, AND FOR THE PAYMENT OF ANY UNPAID BALANCE AFTER PAYMENT HAS BEEN RECEIVED FROM MY INSURANCE CARRIER.

"REFRACTION" IS A SEPARATE CHARGE, IN ADDITION TO THE COMPREHENSIVE EYE EXAM, AND THE FEE IS \$30.00. CPT CODE 92015: REFRACTION: THE DETERMINATION OF THE BEST CORRECTIVE LENSES TO BE PRESCRIBED. MOST INSURANCE CARRIERS CONSIDER THIS TO BE A NON-COVERED SERVICE. THIS PROCEDURE IS DONE AT EACH YEARLY COMPREHENSIVE EYE EXAM TO DETERMINE YOUR PRESCRIPTION AND PAYMENT FOR THIS PROCEDURE IS REQUIRED AT THE TIME OF SERVICE.

DUE TO STATE AND FEDERAL LAW (HIPAA) YOUR PERSONAL HEALTH INFORMATION MUST BE UPDATED AT EACH VISIT. A NEW INFORMATION FORM MUST BE COMPLETED EVERY 2 YEARS. WE APOLOGIZE FOR THIS ADDITIONAL GOVERNMENT MANDATED PAPERWORK.

KELLER EYE CARE AND OUR STAFF WORK VERY HARD TO KEEP OUR SCHEDULED APPOINTMENTS AND TO STAY ON TIME SO OUR PATIENTS DON'T HAVE TO WAIT UNNECESSARILY. IF YOU ARE UNABLE TO KEEP YOUR SCHEDULED APPOINTMENT TIME, PLEASE CALL US TO RESCHEDULE. WE CHARGE A MISSED APPOINTMENT FEE OF \$50.

\_\_\_\_\_  
PATIENT/GUARDIAN SIGNATURE

DATE

**CONTACT LENS FITTING FINANCIAL POLICY**

A CONTACT LENS EXAM/FITTING IS AN INDEPENDENT EXAM, PERFORMED AFTER THE COMPREHENSIVE EYE EXAM AND REFRACTION. IF YOU WEAR CONTACT LENSES, FEDERAL LAW MANDATES THAT A CONTACT LENS EXAM/FITTING BE PERFORMED EVERY 365 DAYS. YOUR CONTACT LENS RX IS ONLY VALID FOR 1 YEAR. IF EXPIRED, CONTACT LENSES CANNOT BE ORDERED UNTIL A NEW FITTING IS DONE.

THE FEE FOR A CONTACT LENS FITTING RANGES FROM \$75 TO \$150 DEPENDANT UPON YOUR BEING A NEW PATIENT, A NEW CONTACT LENS FIT, YOUR RX AND THE COMPLICATION OF THE FITTING. THE COST OF YOUR CONTACT LENSES DEPENDS ON WHICH BRAND YOU ARE FITTED WITH AND YOUR RX. A CONTACT LENS FITTING INCLUDES THE INITIAL VISIT, PROGRESS VISITS UP TO ONE MONTH, AND A PAIR OF CL TRIALS. AT YOUR APPOINTMENT YOU WILL BE INSTRUCTED ON THE PROPER CARE OF YOUR NEW LENSES. THESE LENSES SHOULD BE WORN TO YOUR PROGRESS VISIT SO YOUR VISION CAN BE PROPERLY ASSESSED. ONCE YOUR TRIAL PERIOD IS COMPLETE AND AN RX HAS BEEN GIVEN BASED ON YOUR SATISFACTION AND FIT, AN ADDITIONAL FITTING WILL BE REQUIRED TO MAKE ANY CHANGES TO THIS RX. THE FEE FOR YOUR CONTACT LENS FITTING IS DUE IN FULL AT THE TIME OF YOUR APPOINTMENT. PLEASE LET US KNOW IF THIS POSES A PROBLEM, AND WE WILL BE HAPPY TO RESCHEDULE YOUR FITTING.

WE HOPE THIS POLICY INFORMATION IS HELPFUL AND WILL AVOID ANY MISUNDERSTANDING BOTH NOW AND IN THE FUTURE. IF YOU SHOULD HAVE ANY QUESTIONS CONCERNING THE FINANCES OR THE FITTING PLEASE LET US KNOW.

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PATIENT/GUARDIAN SIGNATURE

DATE