Polices/ Acknowledgment of Notice of Privacy Practices   Name:____________________

FINANCIAL DISCLAIMERS, EXPLAINATION OF FEES, RESPONSIBILITY OF PAYMENT, AND ACKNOWLEGMENT OF NOTICE OF PRIVACY PRACTICES

We accept many **VISION** and **MEDICAL** insurance plans. Please understand that when we verify plan information and bill your insurance, we do so as a courtesy to you. Verification of eligibility is not a guarantee of payment. Because insurance plans can be very confusing, we will do everything we can to have your insurance verified and let you know of your plan information before your exam starts. If you do not agree with what your insurance plan says it covers or doesn't cover we recommend you call your insurance company and/or plan administrator. Your insurance dictates what co-pays, overages, and amounts we collect from you based on the services and/or materials you receive from us, and are due in full on the date of service.

RETURNS AND REFUNDS Because eyeglasses are custom made for each individual we are unable to offer refunds for eyeglasses. In the event of a problem, every effort will be made to exchange or redo the glasses to make any necessary changes. In regards to contact lenses, unfortunately, we are unable to return opened boxes of contact lenses. In the event of a prescription change we may offer to exchange unopened boxes for the appropriate replacements.

Contact Lens Fees--Contact Lens exams consist of a contact lens evaluation **in addition to the routine exam.** Contact lens evaluation services (sometimes referred to as "fittings" by insurances) are **not** an included part of an eye health evaluation and/or routine vision assessment, and additional fees apply. A prescription for contact lenses is NOT WRITTEN without a contact lens exam.

Contact Lens RXs will only be released if the doctor has finalized the prescription; all contact lens RXs expire 1 year from the exam date. If the RX has not been finalized follow-up appointments are scheduled. If the follow-up appointments are routinely missed or not kept, and it has been over 2 MONTHS from the initial fitting then new fitting fees may apply to finalize the RX.

Fees for contact lens evaluation services done on the **same day** of your routine vision exam range between $60 (spherical fit), $75 (toric, soft bifocal contacts, monovision, simple RGP fits), $90 (new wearer to contact lenses), and $150.00-350.00 (specialty RGPs, bifocal RGPs, Keratoconic or other medically necessary fits). For contact lens evaluations done three months after the initial routine vision exam, fees range from $90-155.00. As with glasses, contact lens materials are additional.

NOT ALL INSURANCES HAVE BENEFITS AND COVERAGE FOR CONTACT LENS SERVICES AND/OR MATERIALS. If there is a benefit for contact lens services and/or materials, your insurance will specifically dictate what co-pays or amounts we collect from you based on the materials and/or services provided and are due in full on the date of service.

Refraction Fee--The part of your evaluation that determines your prescription is called a refraction. A refraction is also done under certain circumstances for diagnostic purposes. If you have vision benefits such as VSP, EyeMed, Davis Vision, your refraction is typically included with your exam benefits. Medical insurances that do not include routine vision benefits, such as Medicare, do not cover a refraction. **The fee for a refraction is $20.**

IF I AM USING MEDICAL OR VISION INSURANCE, I AUTHORIZE MY PLAN CARRIER TO DIRECTLY PAY MAYER EYE CARE. I ALSO AUTHORIZE MAYER EYE CARE TO RELEASE ANY INFORMATION REQUIRED FOR PAYMENT TO BE MADE. IF MY PLAN CARRIER DOES NOT PAY OR PARTIALLY PAYS, I UNDERSTAND I AM RESPONSIBLE FOR PAYMENT IN FULL OR THE REMAINING BALANCE. IF I AM NOT USING ANY INSURANCE, I UNDERSTAND THAT PAYMENT IS DUE IN FULL AT TIME OF VISIT.

My signature below verifies that I fully understand this agreement which includes the financial disclaimers, explanation of fees, and the responsibility of payment.

Signature of person responsible for account:____________________

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES (HIPAA)-- **In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for services, and to conduct healthcare operations involving our office. The Privacy Policy (HIPAA) describes these uses and disclosures in detail.** By my signature below, I acknowledge that I have been offered and/or received a copy of the Privacy Policy from Mayer Eye Care.

Signature of person responsible for account:____________________

Printed name of person responsible for account:____________________ **Date:**____________________