ABOUT YOUR INSURANCE

There are two types of insurance that will pay for your eyecare services and products. You may have both and our practice may accept both:

1. Vision Care Plans (VSP, EyeMed, Superior, VCP, etc.)
2. Medical Insurance (Blue Cross Blue Shield, Medicare, etc.)

Vision Care Plans cover only a basic comprehensive examination for eye diseases, eyeglasses and contact lenses. They do not cover diagnosis, management or treatment of eye diseases. I have had explained to me that my contacts lens prescription will be given to me after the completion of my contacts lens fitting without me requesting it, but I do not wish to receive it. I understand that if I'm a new or an established contact lens wearer, I'm responsible for paying the appropriate annual contact lens examination fee prior to leaving the clinic.

Medical Insurance must be used if you have any eye health problem or systemic health problem that has ocular conditions. Your doctor will determine if these conditions apply to you, but some are determined by your case history. If you have both types of insurance, it may be necessary for us to bill some services to one plan and other services to the other. We will use coordination of benefits to do the properly and to minimize your out of pocket expense. We will bill your insurance for services. We will try to obtain advanced authorization of your insurance benefits so we can tell you what is covered. If some fees are not paid by your plan, we will let you know of any unpaid deductibles, co-pays, or non-covered services as allowed by the insurance contract at the time of service. We will bill you for any unpaid claims or any additional patient responsibility as deemed by your insurance after the claims have been processed.

I have read, understand, agree with, and will comply with the above policies and information. I am signing it voluntarily.

Patient Signature_____Date_____

If you are signing as a personal representative of the patient, please indicate your relationship

Representative_____Relationship_____

Please provide your insurance card(s) to our staff member.

Arkansas Family Eyecare of Malvern

Please turn page over

Receipt of Notice of Privacy Policies & Consent Form

Arkansas Family Eye Care
1023 South Main St. Malvern, AR 72104
Telephone 501-332-6262
Fax 501-337-0373

Patient Name:_____ Phone Number:_____

Patient Address:_____

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 our services and to conduct health care operations involving our office.

The *Notice of Privacy Practices* you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our *Notice of Privacy Practices*, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third party payers and insurers; and (4) other aspects of payment described in our *Notice of Privacy Practices*. Our *Notice of Privacy Practices* will be updated whenever our privacy practices change. You can get an updated copy here at the office.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have received a copy of our *Notice of Privacy Practices.*

You have the right to ask us to restrict the uses or disclosures made for purposed of treatment, payment or healthcare operations, but as described in our *Notice of Privacy Practices,* we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our *Notices of Privacy Practices* describes how to ask for restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the *Notices of Privacy Practices* from Arkansas Family Eye Care.

_____ _____

Signature Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

_____ _____

Relationship to patient Print Name

Source of Authority_____

Please turn this page over

Arkansas Family Eye Care

HIPPA Authorization Form

Date: _____

Patient's Name: _____

DOB: _____

I authorize Arkansas Family Eye Care to disclose my PHI (Protected Health Information) to any person(s) indicated other than providers. This would include family, friends, guardian etc.

Name: _____ Relationship: _____

Name: _____ Relationship:_____

Name: _____ Relationship: _____

Signature: _____

By signing this I certify that all the above is true and correct. I understand I have the right to revoke this authorization at any time and that it is my responsibility to request a new HIPPA for to make changes should any occur.

MEDICARE

Name _____ Medicare # _____ Effec. Date _____ Birthdate _____

COVERAGE OVERVIEW

As one of our patients age 65 and older, Medicare is your primary health insurance. For your convenience, our office is a participating provider with Medicare. This means that our office bills Medicare for your office visits, tests and materials. Medicare then reviews all submitted claims and if approved, reimburses our office 80% of the approved amount. The remaining 20% (the co-payment) is your responsibility as the Medicare beneficiary. You may also be responsible for a deductible and certain non-covered fees, as described below. Our office may elect to: 1) bill you directly for your portion of the fees, or 2) bill your **supplemental insurance,** if you carry it.

Suppl. Ins. ❑ No ❑ Yes

Carrier Name _____

Address _____

Policy # _____ Effec. Date _____

DEDUCTIBLE

Medicare has a yearly deductible of **$100** that takes effect each January. If our office is the first to submit Medicare claims for you each year, Medicare will notify us that you have not yet met your deductible for the year. Medicare will not pay for your allowable fees until the deductible is met.

EXCEPTIONS, NON-COVERED SERVICES & MATERIAL FEES

- ❑ Medicare does not pay for **refractive services**. This is the part of your eye exam that determines your prescription.
- ❑ Medicare will not pay for **any** services if the doctor **only** makes a refractive diagnosis during your exam. For example, if it is a routine exam only to determine your prescription (far or near sighted) and no separate medical diagnosis is made, Medicare will not cover any fees for that visit.
- ❑ Medicare does not cover glasses or contact lenses **unless you have had cataract surgery**. If you have a lens implant, Medicare will cover your lenses one time, plus one standard frame, **per operation**.

  R _____ L _____ Surgeon _____
  Date(s) of surgery

- ❑ Medicare does not cover **deluxe frames**. (Standard frames are available, which are subject to the 20% co-payment.) Medicare does not routinely cover lens treatments, such as **scratch coating, UV coating** and **oversize lenses**. These extra charges will be your responsibility.

  Deluxe frame extra charge: $ _____ Lens treatment(s): $ _____

- ❑ Medicare will only pay for services that it determines to be **"reasonable and necessary"** under code section 1862(a)(1). If Medicare determines that a particular service, although it would be otherwise covered, is not "reasonable and necessary" under their standards, Medicare will deny payment for that service. The doctor believes that, in your case, Medicare is likely to deny payment:

  For _____ because _____

  For _____ because _____

  For _____ because _____

  For _____ because _____

AUTHORIZATION STATEMENT / SIGNATURE

I have read and understand the information above and agree to pay for any services and materials I order, but which are not covered by Medicare.

Patient/Beneficiary Signature _____ Date _____

Print Name _____

White: Office Yellow: Patient