

## *Payment Policy of iCare EyeCare DBA: Morris Avenue Eyecare*

The best doctor-patient relationships are maintained when there is a complete understanding of the treatment/materials provided and the fees charged for those services and/or materials. Please feel free to discuss the fees for any services and/or materials at any time with the doctors or staff.

The payment policy of **iCare Eyecare** is full payment is due for services rendered and materials provided on the same day unless other arrangements are made prior to the date of services or provision of materials. If you have insurance, co-payments, all non-covered charges from the visit, and payments towards your deductible are due at the time of service.

## *Routine Vision Exam vs. Medical Office Visit*

A medical office visit may be needed in order to diagnose and treat acute eye infections, eye injuries, eye diseases (such as diabetes, cataracts, glaucoma among others) and allergies. These visits do not fall under routine vision care since they are more complex and require more time to treat. Sometimes it is not possible to know before hand if an examination qualifies as routine vision care or a medical office visit. These fees are different depending on the amount of testing required as well as the complexity of the problem.

## *EyeWear/Vision Insurance vs. Medical insurance*

We often have patients that have both vision and medical insurance. They are very different in terms of the services they cover and it's important for our patients to understand those differences. EyeWear/Vision insurance is designed for routine examinations to determine a prescription for glasses or contact lenses. It is not available to treat complex medical conditions and/or diagnoses and does not require a detailed examination of the retina.

When a medical diagnosis or condition is present (such as diabetes, cataracts, glaucoma, red eyes or other eye diseases) it is necessary to file the visit with your major medical insurance and the co-pays for that insurance will be due as well as any non-covered service.

If your appointment is for a routine examination and you have diabetes, the standard of optometric care includes fundus photography. **These photographs will be filed to your major medical insurance company and not your eyewear/vision insurance carrier.** We do not know if your major medical insurance company will pay for these services or if they will be applied towards your deductible. **You will receive an explanation of benefits from your major medical insurance company advising what they paid and what you owe our office.**

Our office does not make these rules. The insurance carriers themselves define them. There is no way to know prior to the examination which type of insurance our office will be able to file for you. We accept most major medical insurance plans for your convenience and we will file those claims for you. In the event that we do not take your major medical/vision insurance, full payment is due at the time of service and we will provide you with an itemized receipt so that you may file with your carrier for reimbursement. If you have any questions, please let us know prior to your exam.

***For those patients with medical/vision insurance, your insurance coverage is a contract between you and your insurance company. It is your responsibility to determine what is covered under your particular insurance plan and to verify any deductibles, co-insurance or copays. We cannot be held responsible for any misunderstandings between you, the patient, and your insurance company. You will be responsible for any portion of your account not paid by your insurance coverage.***

I authorize payment of any medical/vision benefits to **iCare EyeCare** for any services rendered. I hereby agree to pay any outstanding balances not covered by insurance coverage. I authorize **iCare Eyecare** to release information needed to determine these benefits or the benefits payable for related services to my insurance carrier.

I understand the above paragraphs.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient Signature, Parent or Guardian if the patient is a minor)