Agreement to Pay for Services and Materials

This consent authorizes Family Eye Care Associates to bill you and/or your insurance company for services and materials provided by our office. If you have medical or vision insurance please provide your insurance cards to our staff member.

There are two types of health insurance that will help pay for your eye care services and materials. You may have both vision and medical insurance and our practice accepts both:

1) Vision care plans (such as VSP and Eyemed)

2)Medical Insurance (such as Blue Cross/Blue Shield and Medicare)

Vision care plans only cover vision exams along with eyeglasses and contact lenses. Vision plans only cover a basic screening for eye disease. THEY DO NOT COVER DIAGNOSIS, MANAGEMENT OR TREATMENT OF EYE DISEASES.

Medical insurance must be used if you have any eye health problem/complaint or systemic health problem that has ocular complications. 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 plans 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 this properly and to minimize your out of pocket expense.

We will bill your insurance plan for services and/or materials if we are a participating provider for that plan. 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, you will be responsible for payment. We will bill you for any unpaid deductibles, co pays or non-covered services as allowed by the insurance contact.

Your signature on this form will serve as your "signature on file" for processing insurance claims.

I have read and agree with these polices.

Patient / Agent / Guardian Signature 04/30/2020

I acknowledge that I have been offered a copy of Optometry, P.C. dba Family Eye Care Associates Notice of Privacy Practices.

Signature_____ **Date**_____

Patient Name (Please print)_____

Relationship to Patient (if signing for a minor)_____

Family Eye Care may release my information to the following family member(s)

Name_____ **Relationship to Patient**_____

Name_____ **Relationship to Patient**_____

Family Eye Care is going green! Just supply us with the following to receive reminders by text or e-mail.

Cell #:_____

E-Mail:_____

May we leave a message with a family member? _____**Yes** _____**No**

May we leave a message on voicemail? _____**Yes** _____**No**