SNEAD EYE GROUP

HIPAA Acknowledgment

I acknowledge that I have been given an opportunity to review the Notice of Privacy Practices of Snead Eye Group & Eye Physicians and Surgeons of Florida.

Patient Signature	Date	Acct

Payment of Non-Covered Services

The **REFRACTION** is a **non-covered service** for insurance companies. The refraction is a diagnostic test used to determine the amount of corrective lens power required to obtain your best vision. Results of this test are utilized for eye glass prescriptions or to provide measurements for the lens power inserted during cataract surgery. The information provided by the refraction helps the doctor to make accurate medical decisions for your vision care. The **refraction fee is $40.** Without the refraction, we are unable to provide you with a prescription for glasses.

I acknowledge that I have been informed of the following:

1. Known non-covered services are due and payable at the time of service.
2. It is my responsibility to advise the technician or doctor if I do not want a non-covered service before it is provided.
3. Insurance may not pay for all services in full. I may have a co-pay amount or a co-insurance amount due at the time of service or after insurance processes my claim, and I will be responsible for payment.
4. I must provide a correct copy of my insurance card at the time of service. If I fail to do so and timely filing limit passes, I will be responsible for all charges for services rendered.
5. I must provide the office with information regarding any specific vision insurance prior to being seen by the doctor so that an authorization can be obtained. I understand that an authorization to utilize vision insurance is required from the vision insurance company and cannot be obtained after being seen. I understand that a medical diagnosis requires submission of my claim to my medical insurance rather than to my vision insurance.

Cancellation / No Show Policy for Doctor Appointment

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. **If an appointment is not cancelled at least 24 hours in advance you will be charged a forty dollar ($40) fee; this will not be covered by your insurance company.**

This consent will remain in effect until revoked by the patient/guarantor in writing.

Signed:_____ Date:_____

Parent/Guardian:_____ Date: _____

PLEASE PRINT PATIENT NAME HERE: _____

The **CONTACT LENS EVALUATION** or **RE-EVALUATION** is a **non-covered service** for insurance companies. Any patient requesting contact lens for the first time from us must have an evaluation. The fee includes taking the proper measurements of your eye to determine what lens fits you best, and follow up visits for contact lens checks during the fitting process for **60 days** for a non-medically necessary lens. Specialty lens or medically necessary lens such as those lens for Keratoconus, multifocal, gas permeable or scleral lens, or lens needed for corneal issues will have a longer fitting process that will be determined by the doctor. In all cases, the manufacturer only provides a 60-day warranty on the lens. **Lens, regardless of type, cannot be returned after 60 days from the order date for any reason.** Contact lens cannot be trialed, ordered or dispensed without a contact lens evaluation. All lens types require an evaluation.

New Lens Wearer or Change in Lens Type $85 - $200 Medically Necessary Fee/Keratoconus $345 and up
Re-Evaluation Fees $65 - $115