Midtown Optometry Patient Financial Responsibility Disclaimer Statements

Patient Name/Guardian:_____

This Notice Applies to the Following Family Members:_____

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1. **Advance Beneficiary Notice:**

   Eligibility for medical insurance and/or routine vision benefits:

   We will attempt to verify your plan eligibility for services and/or materials before your appointment. Verification of eligibility is done as a courtesy only and is not a guarantee of payment. Please check with your plan administrator if you have any questions regarding eligibility. Midtown Optometry does not participate in any HMO plans.

   Liability:

   If I have medical insurance or routine vision benefits, I authorize my plan carrier to directly pay Midtown Optometry. I also authorize Midtown Optometry to release any information required for payment to be made. **If my plan carrier does not pay, or partially pays, I understand that I am responsible for payment in full of the remaining balance.** My signature below verifies that I understand this agreement and the above financial disclaimers.

   Signature_____Date_____

2. **Contact Lens Fees:**

   Contact lens evaluation services may not be included as part of your routine vision benefits and additional fees may apply. Fees are customized according to the complexity of the case and the predicted time necessary to care for the individual patient. **You must have a valid prescription for eyeglasses in order to have a contact lens exam and prescription.**

   My signature below verifies I have reviewed the Contact Lens Program Form.

   Signature_____ Date_____

3. **Refraction Fee:**

   The part of your evaluation that determines your prescription is called refraction. Refraction is also done under certain circumstances for diagnostic purposes. If you have routine vision benefits such as Vision Service Plan, EyeMed, or Medical Eye Services, your refraction is typically included within your exam benefits. Medical insurances that do not include routine vision benefits, such as **MEDICARE, do not cover refraction**. The fee for refraction is $45.

   My signature below verifies that I understand the refraction fee.

   Signature_____Date_____

4. **24- Hour Cancellation Fee:**

   You will be responsible for a $25 cancellation fee for your appointment if we do not receive notice within 24 –hours.

   My signature below verifies that I understand the 24-Hour Cancellation Fee.

   Signature_____Date_____