Patient Name: ____________________________________ **Date:** ________________

INSURANCE AND BILLING POLICIES

There are two types of insurance that helps pay for your eye care services and products.

1. **Vision care plans** such as VSP and EyeMed
   -These plans only cover routine vision exams. They may also pay for glasses and contact lenses. Vision plans only cover basic testing for eye disease. They do not cover diagnosis, management and treatment of eye disease.
2. **Major medical insurance** such as Medicare and Anthem
   -Medical insurance must be billed if you have any eye health or systemic health problems that have ocular complications. Your doctor will determine if these conditions apply to you.

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 when it is allowed by the insurance company to do this properly and try to minimize your out-of-pocket expenses.

FINANCIAL DISCLOSURE

Please note that our office requires a 50% down payment for materials on the day of ordering. The balance is due on the day that materials are dispensed. A 5% cash discount is available for full payment by cash or check at the time of ordering your glasses. This discount is not available on contact lenses or examinations. Payment for examination services is expected on the day that the service is performed unless other arrangements are made in advance.

SIGNATURE ON FILE

I understand that I am expected to pay for all services when rendered unless other arrangements are made in advance. Kenton Family Eye Care, Inc. will gladly complete my insurance forms so payment can be made directly to me. I will be reimbursed immediately if my insurance check is sent to Kenton Family Eye Care, Inc. in error. This signature on file below is my authorization for the release of all information necessary to process my claim. I further understand that I am financially responsible for all charges whether or not the services are paid by my insurance. Additionally, this signature on file is my authorization to release all information necessary to coordinate care with other health care providers.

Signature: ____

Patient or other person responsible for payment on this account