ASSIGNMENT OF MEDICAL BENEFITS & APPOINTMENT CANCELLATION POLICY FORM

(1) **Comprehensive eye exams** include all professional services related to the evaluation and treatment of your eye and visual health. In particular, **routine eye exams** (i.e., presenting only with symptoms of blurred vision, without any acute / chronic eye health conditions / diseases) and **refractions** (i.e., the determination of your eyeglass prescription) are usually covered by ***vision insurances***, but NOT ***primary health insurances***. (MEDICARE, for example, does NOT cover either, and they are considered out-of-pocket expenses.) A referral is not a guarantee of payment.

(2) **Treatment of eye diseases**, either upon initial presentation or otherwise following the initial comprehensive eye exam, is a **separate billable service**. While treatment of eye diseases is **not covered** by ***vision insurances***, it is usually covered by ***primary health insurances***, including MEDICARE.

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 plan. We will follow a procedure called ***coordination of benefits*** to do this properly, in order to minimize your out-of-pocket expense.

(3) **Contact lens fittings are a separate billable service from comprehensive eye exams** (although they may be rendered on the same day), and a comprehensive eye exam within one year is an obligatory prerequisite for contact lens fittings. They may or may not be covered by your ***vision insurance*** and usually are not covered by your ***primary health insurance***, including MEDICARE. Any subsequent follow-ups to refine the contact lens prescription are included at no charge for 90 days, or up to five follow-up visits, unless otherwise stated at the time of examination.

I understand that professional fees collected for services rendered during a contact lens fitting (even if unsuccessful) are non-refundable. I also acknowledge that, by the successful completion of my contact lens fitting / evaluation, I will have received a prescriber-retained copy of my contact lens prescription (unless otherwise specified by me) and understand that I may purchase contact lenses from a seller of my choice.

APPOINTMENT CANCELLATION POLICY: I am aware that if I have scheduled an appointment, which has been confirmed by e-mail, text, telephone, or answering machine message, that I am responsible for a **$50 NO-SHOW FEE if that appointment is not canceled within 24 hours of the actual appointment**. Exceptions are given in the case of emergencies, such as for medical reasons.

I assign all of my medical benefits, including all benefits to which I am entitled through Medicare, private insurances, and any other health plans, to **PARK L. HSIEH, O.D., A PROFESSIONAL OPTOMETRIC CORPORATION (D.B.A. EYE LOVE OPTOMETRY)**. A photocopy of this assignment is to be considered as valid as an original. I authorize said assignee to release all information necessary to secure payment of benefits paid and not paid by my insurance company.

Benefits quoted to me are not a guarantee of payment by my insurance company, and that final determination can only be made when the claim is processed. For example, as a Medicare Participating Provider, we agree to accept the charge determination of the Medicare carrier as the full charge for services rendered, but the patient is still responsible for the **co-insurance**, **deductible**, and any **non-covered services**. The co-insurance and deductible are based upon the charge determination of the Medicare carrier, which can only be confirmed after the insurance claim has been submitted.

I understand that, if some fees are not paid by my insurance, I am still financially responsible and will be billed for them. All known co-payments, deductibles, and charges for non-covered services are **due at the time** that they are rendered. Accounts 90 days-old are subject to collections, and there will be a service charge for any bounced checks. It is my responsibility to know my own coverage.

Patient Name: _____

Patient Signature: _____ Date: _____