## About your insurance

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

1. Vision care plans (such as VSP, Eye Med, Davis, Superior, CEC, etc.)
    - Vision care plans only cover routine vision exams along with eyeglasses and contact lenses. Vision plans only cover a basic screening for eye disease. They do not cover diagnoses, management, or treatment of eye diseases.
2. Medical Insurance (such as Blue Cross Blue Shield, United Health care, etc.)
    - Medical Insurance must be used if you have any eye health problem or systemic health problem that may affect your eyes. Your doctor will determine if these conditions apply to you, but some are determined by your health history as well as risk factors. (Examples: Diabetic Retinopathy, Hypertensive Retinopathy, Glaucoma, Macular Degeneration etc.)

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 if we are a participating provider for that plan. If some fees are not paid by your plan, you are responsible for any unpaid deductibles, co-pays, or non-covered services as allowed by the insurance contract.

## Retinal Photography

As a part of the comprehensive eye exam, our doctors require Retinal Photography. The imaging fee is $39.
If a medical condition is found, then these photos will be billed to your major medical insurance. Filing initial findings as necessary will help with coverage for additional testing, follow ups, and/or treatments. A co-pay or deductible may apply in lieu of the $39 imaging charge.
Payment is expected at the time of treatment. Any deductibles, co-payments and non-covered services must be paid at the time of visit unless otherwise specified. We will be glad to help you fill out any insurance forms that your plan may require.

I have read & agree to the office insurance practices.

| _____ | _____ | _____ |
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| Print Patient Name | Signature (guardian if minor) | Date |