Ridgedale Family Eye Care

Policy on Insurance

Please note as of August 1st, 2016, all patients will be required to know their vision and medical health insurance information at time of visit. There are two separate insurances in eye care. Those for routine eye exams (ex. Exams for eyeglasses and contact lenses) and those for medical conditions relating to eye (ex. Conjunctivitis, glaucoma, cataracts, etc.) If you are not aware of your coverage at the time of your exam, you will assume the full cost of service at the time of your visit. All non-covered, or partially covered services (contact lens exam, refraction, optomap scan) will be due at time of visit. We will not be able to accept assignment for the services and materials after the services have been rendered. Due to the frequently changing healthcare environment and long on-hold times we will be unable to search for individual coverage. Many medical insurance plans will have a separate plan for vision coverage with separate ID numbers. Once we know your coverage we will gladly obtain an authorization for you and accept payment from any plan we participate in. Thank you for your cooperation.

Initial _____

Policy on Contact Lens Fittings and Insurances

In order to obtain a valid contact lens prescription, the doctor must perform what is called a contact lens evaluation; brief confirmation of the vision and health of the eye when wearing contacts. Some insurances pay a portion of this charge, but many do not. If your insurance does not cover this charge, you will be responsible for this expense, and must be paid prior to the contact lens prescription being released. The cost of a contact lens fit at our office ranges from $75-$225, depending on the type of evaluation needed. Some exceptions apply to specialty rigid gas permeable lenses.

Initial _____

Cancellation Policy

As of August 1st, 2016, Ridgedale Family Eye Care will uphold a 24 hour cancellation policy. If an appointment is cancelled with less than 24 hours notice, the patient will be responsible for a $50 cancellation fee.

Initial _____

By initialling above, I hereby agree that I understand the policies of Ridgedale Family Eye Care, and will remit payment for services as previously described.

Print Name: _____ Date:_____

Signature: _____