Dr. David Bloch
Adult and Pediatric Optometry

## THINGS TO KNOW ABOUT OUR OFFICE

Thank you for choosing our office for your eye care. In order to provide you with the highest quality patient care, service, and products, we ask that you review, acknowledge, and agree to our office policies and procedures as follows:

**FEES FOR SERVICES AND PRODUCTS:**
Examination fees are charged according to the reason for your visit. If you are here for an annual eye exam, your exam charges are different than if you are here for a specific medical problem with your eye(s).

☐ A **routine eye exam** includes a basic health evaluation and a refraction (determination of lens prescription). The regular fee for a routine eye exam is $145. Extended refractions procedures have additional fees, as do contact lens examinations and fittings (see below). Eyewear, contact lens supplies, and other eye care products are sold separately at various prices depending on the type and brand.

☐ **Contact lens examination and fitting is not part of the regular eye exam. It is a supplemental exam that will incur extra fees based upon the complexity of your lens fit and requirements.** Please note that insurance companies consider most contact lens fits as cosmetic and will not cover contact lens examination and fitting charges. But in some circumstances, they will allow for a discount on the fitting and/or pay for part or all of contact lens materials. Prior to this type of exam, you will need to approve a summary of charges for your contact lens fitting and supply of contacts. On occasion, you may be able to save on cost of lenses through special offers or rebates exclusive to our office.

☐ **Medical visits** include such things as a red eye, eye pain or discomfort, temporary or partial vision loss, infection, inflammation, or injury. Visits requiring treatment other than corrective lenses will be charged a separate office visit fee and any required supplemental procedure fees. Diagnosis and treatment of mid-level medical eye problems start at $100 for prior patient and $125 for new patients.
Please be aware that fees may be more or less based upon the severity of your condition. Treatment rendered after regular business hours as urgent care has a higher fee. Medical eye problems are generally covered by your regular health insurance (if you have coverage).

☐ **Return visits for follow up** and/or **additional tests** to investigate a condition are sometimes necessary. Patients that require extended care or treatment beyond the standard eye exam will need to pay additional fees for those specific tests and return visits. The fees for these services vary and will be explained to you in advance. Some or all of the costs related to those visits may be passed on to your primary health insurance. Please ask the front desk for further information.

☐ Fees for services and products may be less if you have **insurance coverage.** If you have insurance coverage, please indicate your insurance carrier below and give the front desk person a copy for our records. **Also, be aware that having insurance coverage is not a guarantee that your carrier will pay your claim. Insurance plans vary with regard to limits of coverage, co-payments, co-insurance, and deductibles. Therefore, we will collect for medical visits at the time of service and bill your insurance carrier accordingly if we are an in-network provider.** You will be reimbursed for any payments we receive from them on your behalf. **If you have VSP, EyeMed, MES, Tricare Prime, or Medicare eye care coverage, we will only collect your co-payment, co-insurance, and charges for non-covered items.**

**PLEASE PROVIDE INSURANCE INFO:** Insurance Carrier:_____

**(give front desk a copy of your card)**

Group Number:_____

Patient Name:_____

Patient DOB:_____

Subscriber's Name:_____

Subscriber's ID# or SS:_____

Subscriber's DOB:_____

Relationship to patient:_____

Does Patient have additional Insurance? Y N

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**PAYMENTS:**
We accept cash, personal checks, Visa, Mastercard, Discover, Care Credit (payment plan). Please be advised that we charge a $25 fee for returned checks in addition to other bank fees that may be assessed.

**MISSED APPOINTMENTS:**
Scheduling of appointments is based upon availability. We make every effort to give our patients convenient appointment times. It is your responsibility to keep your appointment. If you need to change or cancel an appointment we ask that you give us a minimum 24 hour notice. In this way, we can give other patient's convenient appointment times as well. Please be aware that we charge a $50 fee for short notice cancellation and no show appointments.

**RECORDS RELEASE AND HIPAA** (Health Insurance Portability and Accountability Act)**:**
Your health records and privacy is protected. Information about you and your health cannot be released to anyone without your consent. Full disclosure of our HIPAA policies is posted at the front desk and is available on request. If needed, your records can be transferred with you fill out the proper written release and pay preparation/copy fee. Please be aware that your health insurance company has rights to you health records once you have contracted with them.

**REPORTS AND FORMS:**
On occasion, patients need reports or forms filled out for the DMV, Insurance Companies, Schools, Employment, Military, Etc. Completion of these reports and/or forms requires extra time. Requests for reports and forms will be filled as soon as possible, but may take up to 10 business days depending on the doctor's agenda. The fee to complete forms is $5/page and $45/page to write reports.

**CONSENT FOR RELEASE OF INFORMATION:**
By signing below, you consent to the use and disclosure by Dr. Bloch's office any health information concerning your vision examination and products to any party and/or agent, including, but not limited to your employer, health plan, or plan sponsor, as needed for your treatment, the payment of your vision benefit claims, and related customer communication regarding health care services provided by Dr. Bloch's office (i.e. mailings of exam reminders, recall cards, or explanation of services/products by provided by his office).

This consent for release of information is voluntary and may be revoked by my consent at any time by notifying Dr. Bloch's office in writing, except for any disclosure already taken in reliance of my consent to release of information. You may also request Dr. Bloch's office to restrict the use a disclosure already taken in reliance of your information, however, his office is required to agree to your request.

**RESPONSIBILITY FOR PAYMENT AND BILLING ERRORS:**
By signing below, you certify that the insurance coverage you have indicated for yourself or dependent above is accurate and true to the best of your knowledge. You authorize Dr. Bloch's office to submit a vision benefit claim for payment to any third party as indicated above. You also assign directly to Dr. Bloch all insurance benefits, if any, otherwise payable to you for services and products rendered.
You are responsible for all charges incurred during any and all your visits. If there is a billing error or your insurance company/third party fails to pay a claim, we will notify you of any unpaid balances. You agree to pay any outstanding balances promptly and the associated late fees on past due charges. If you account becomes delinquent, it will be passed to a collections agency and you agree to pay the sum total of the unpaid balance, late fees, collection fees, and possible attorney fees.

**By signing below, I understand and agree to all of the above policies, procedures, and fees.**

| Signature of Patient/Responsible Party | Printed Name | Date |
|---|---|---|
| Signature of Patient/Responsible Party | Printed Name | Date |