COMMERCE VISION GROUP, LLC

FINANCIAL POLICY

The doctors and staff are committed to providing you with thorough, professional eye care. If you have medical insurance that covers eye care or other vision insurance, we will be glad to complete any forms you may have and assist you in obtaining your maximum allowed benefits.

Payment for services is due at the time the services are rendered unless other payment arrangements have been made and approved by our staff. We prefer payment in full when ordering glasses and contacts. However, a deposit of 50% can be made to initiate the order. The remaining balance will be due at dispensing.

We accept **CASH, CHECKS, VISA, MASTERCARD, DISCOVER and CARE CREDIT.** There will be a $35 charge for any returned check fee for non-sufficient funds.

Insurance: We participate and accept assignments on several vision and medical plans. This means that the time of the exam, you will be responsible for any co-payments, deductibles or fees for non-covered services. We will bill and receive payment directly from your insurance carrier for covered services. You will be responsible for any remaining balance.

There will be a $25 refraction fee, if we file your medical insurance and you receive a prescription for glasses or contacts. The refraction is not covered under any medical insurance plan; therefore, it is the patient's responsibility and paid at the time of service.

If you need a referral from your primary provider it is your responsibility to obtain that referral prior to your examination. A referral with an authorization number is not a promise to pay for that visit. If for some reason you were not eligible for services at the time of the examination, your insurance may deny payment and you will still be responsible. Please realize that your insurance coverage is a contract between you and your insurance company. Our fees for covered services normally fall within acceptable ranges set by most insurance companies and are usually covered up to the maximum allowance set by each carrier. Not all services are a covered benefit in all contracts and routine eye care and or other selected procedures may be specifically excluded making the patient responsible for the charges.

We must emphasize that as eye care professionals our relationship is with you and your insurance company. You are ultimately responsible for all fees for other services and materials delivered to you by this office. We realize that temporary financial problems may affect timely payment on your account. If such problems do arise we encourage you to contact us promptly and we will assist you in providing you a payment arrangement.

Our employees will be happy to assist you if you have any questions about the above information or your insurance coverage.

Thank you for choosing ***COMMERCE VISION GROUP*** for your ***EYE CARE*** needs.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for **Commerce Vision Group, LLC** to use and disclose Protected Health Information **(PHI)** about me to carry out Treatment, Payment and Health Care Operations **(TPO).** The Notice of Privacy Practices provided by Commerce Vision Center describes such uses and disclosures more completely.

I have the right to review the ***Notice of Privacy Practices*** prior to signing consent. **Commerce Vision Group, LLC** reserves the right to revise this Notice of Privacy Practices at any time.

With this consent, **Commerce Vision Group, LLC** may call my home or alternative number and leave a message on voicemail or in person for any items that assist the practice in carrying out our **TPO**, such as appointment reminders, insurance items, notification of referrals to specialist, and any calls pertaining to my clinical care including test results and notification that ophthalmic prescriptions are ready to dispense.

With this consent, **Commerce Vision Group, LLC** may mail to my home any items that assist the practice in carrying out **TPO**, such as appointment reminder cards, payment statements and notices of upcoming promotions.

With this consent, **Commerce Vision Group, LLC** may disclose health information to notify or assist in the notification including locating a family member, your personal representative or another person responsible for your care of your location or your general conditions. We will provide you with the opportunity to object to such uses or disclosures. We will also use our professional judgement and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up ophthalmic prescriptions, medical supplies or similar forms of health information.

We may use or disclose your health information when we are required by law to do so. This includes reasonable belief that you're a possible victim of abuse, neglect or other crimes. It also includes disclosure for judicial and administrative proceedings, such as in response to court order of subpoena. Reasons of public health, such as contagious disease reporting and warning on medical devices or drugs from the FDA are also included.

We will not use your health information for marketing communications without your written authorization.

I have the right to request that **Commerce Vision Group, LLC** restrict how it uses or discloses my **PHI** to carry out **TPO**. This practice is not required to agree to my requested restriction but if it does it is bound by this agreement.

I may revoke my consent in writing to the extent that the practice has already made disclosure in reliance upon my prior consent. If I do not sign this consent, or later revoke it **Commerce Vision Group, LLC** may decline to provide treatment to me.

COMMERCE VISION GROUP, LLC

Contact Lens

Providing our patients a contact lens prescription requires our office to:

- Perform a complete eye examination to assess the health of the eye and determine the patient's prescription
- Measure the curvature and size of the cornea to determine proper fit of the contact lens.

The complete eye examination and the contact lens fitting are separate procedures and are therefore, charged per each procedure. Patients that request a prescription for contact lens will be responsible for payment of both the examination fee and the fitting fee. The fitting fee for the contact lens fit is an additional **$60.** Some of the vision plans will have a discount on this fee, but most insurance companies do not cover these services. Therefore, this fee is collected at the time services are rendered.

This fee includes **90 days** of follow up care associated with the contact lens fit.

Minors must have written consent from a parent or legal guardian in order to receive a contact lens exam.

The cost of the contact lenses will be provided upon determination for the lens design required. A 50% deposit is required prior to ordering with the balance due at the time the lenses are dispensed.

The first or initial pair of contact lenses are verified and inspected for defects prior to the initial dispensing. Any damage incurred after dispensing is the responsibility of the patient.

By state law, contact lens prescriptions are valid for 1 year. Replacement lenses will be dispensed only to those patients whose prescriptions remain valid and have not surpassed the expiration date.

A written copy of the contact lens prescription may be released to the patient in accordance with Federal requirements and patient compliance guidelines. Lenses purchased from other sources or suppliers will not be warranted for defects. It is the patient's responsibility to ensure that all lenses purchased from another supplier meet the exact specifications (prescription and or lenses powers and brand of lens) as prescribed by our office.