Levine Eye Center
33 Lincoln Avenue
Rutherford, NJ 07070

AN IMPORTANT MESSAGE ABOUT INSURANCE COVERAGE

There are two types of insurance that will help pay for your eye care services and products.

1. **Vision insurance** (ie: VSP, EyeMed, NVA etc)- one routine exam per year and glasses and/or contact lenses depending on coverage. Vision plans only cover a basic health check and not the diagnosis, management, or treatment of eye diseases.

2. **Medical insurance** (ie: Blue Cross, Medicare, etc)- health problems that effect the eye such as allergies, dry eye, glaucoma, diabetes, or loss of vision etc. **They do not usually cover a check of your glasses or contacts prescription. Refractions are $50 and not covered by medical insurance.**

Testing and follow up appointments are NOT routine and are only billed to medical insurance.

It is your responsibility to provide us with your current insurance information at every appointment. **If your plan requires a referral, it is your responsibility to obtain one for your appointment.**

As a courtesy we will bill your insurance plan for services if we are a participating provider. You will be billed for any deductibles, co-pays, and services as allowed by your insurance contract. **You are responsible to know your insurance coverage.** Please call your insurance carrier if you have any questions.

I authorize the release of any medical or pertinent information necessary to process my claim. I authorize payment of medical benefits to Marie R. Levine OD. I understand that I am responsible for any charges not covered by my insurance plan.

Signature_____Date: _____

The law requires that Marie R Levine OD (Levine Eye Center) make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

_____I was given the opportunity to read, have read, or had explained to me Levine Eye Center's Notice of Privacy Practice prior to any services offered.

_____The Notice of Privacy Practice could not be read due to the emergent nature of care and will be acquired when possible.

_____I was given the opportunity to read, have read, or had explained to me the Levine Eye Center's Warranty, Exchanges and Return Policy.

_____Our office may use standard email for communication. Standard email is not secure and does not guarantee privacy. I authorize the use of standard email, knowing there is a risk involved for communication

I have read and understand this form and am signing it voluntarily

Signature_____Date: _____

Relation to Patient if acting as representative_____

Date:_____

First Name:_____Last Name:_____

DOB:_____ Age:_____SSN:_____

Address:_____

Phone:_____ Cell:_____

Race/Ethnicity:_____ Sex: M F Decline to Specify

Marital Status: Single Married Divorced Widowed

Vision Insurance Company:_____ ID:_____

Policy Holder Name:_____ DOB:_____

Primary Insurance Company:_____ID:_____

Policy Holder Name:_____ DOB:_____

Policy Holder SSN:_____

Secondary Insurance:_____ Policy Number:_____

Policy Holder Name:_____ DOB:_____

Policy Holder SSN:_____

Please list any <u>eye</u> problems/diseases/ surgeries you have previously been treated for: _____

_____

Are you having any problems with your eyes?_____

Do you or any of your family any history of the following eye diseases:

Macular Degeneration Yes____ No____ Relationship_____

Glaucoma Yes____ No____ Relationship_____

Other:_____

Please list any medical conditions and any surgical history:_____

_____

Do you OR anyone in your family have problems with any of the following: Please indicate self or family

Fever	Yes / No	Self / Family	**Weight Loss**	Yes / No	Self / Family
Heart	Yes / No	Self / Family	**Ear/Nose/Throat**	Yes / No	Self / Family
Endocrine	Yes / No	Self / Family	**Respiratory**	Yes / No	Self / Family
GI	Yes / No	Self / Family	**Muscular**	Yes / No	Self / Family
Skeletal	Yes / No	Self / Family	**Skin**	Yes / No	Self / Family
HIV	Yes / No	Self / Family	**TB**	Yes / No	Self / Family

Do you smoke? Yes / No If so, packs per day:_____Years Smoking:_____

Do you drink? Yes / No If so, drinks per day:_____

Signature:_____ Date:_____

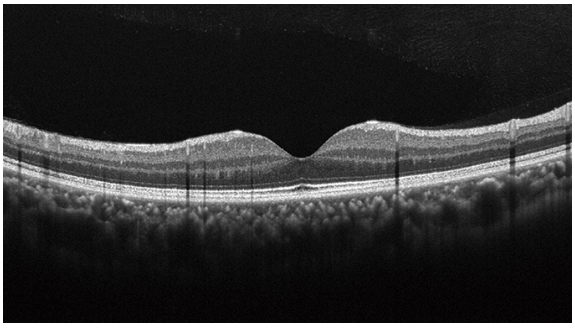
(Parent if Patient is a Minor)

Retinal Health Screening

We offer some of the most up to date technology to help our patients safeguard their health. In addition to your normal exam we recommend a retinal photograph and Ocular Coherence Tomography (OCT). **Insurance does not pay for these tests.**

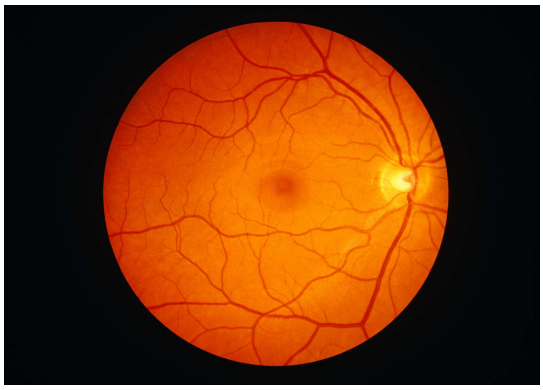
What does it check for? Complications from:

- Glaucoma
- High blood pressure
- Macular Degeneration
- Diabetes
- Signs of stroke
- Tumors
- and many other threatening conditions



OCT: What is it? $39

This non-invasive retinal scan allows us to see and measure all the layers of the retina. The OCT is recommended for all of our patients, especially those with Diabetes, high blood pressure, and those with a family history of eye diseases.



Retinal Photo: What is it? $39

a high definition 200 degree photograph that allows us to carefully examine the retina and check for many abnormalities and diseases.

These tests provide an in depth assessment of the health of the back of the eye and are *strongly recommended by the doctors.*

The discounted rate for the full eye health screening (OCT and photo) is ***$49 and is NOT covered by insurance.***

Please check the appropriate line:_____**YES** I want the FULL retinal screening $49

_____**YES** I want the PHOTO ONLY $39

_____NO I do not want the screening

Signature:_____ Date:_____

Missed appointment policy

In order to provide you with high care, please arrive on time to each appointment. If you are over 15 minutes late, your appointment may be canceled for that day and you may need to be rescheduled. If you need to cancel your appointment, please let us know 24 hours before your scheduled appointment time.

A "missed appointment" occurs when a patient:

1. **Does not show up for an appointment**
2. **Cancels/reschedules to a new day with less than 24 hours notice**
3. **Is more than 15 minutes late and cannot be seen**

We understand patients can't always make it to scheduled appointments, we do request that you inform us of any changes with 24 hours notice.

Our office has a policy in place where we charge $40 for a missed appointment. This charge won't be applied if you let us know 24 hours in advance.

When you miss an appointment it creates empty slots for our doctors which can not be used to serve other patients. We hope you understand the importance of letting us know.

Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. Patients with frequent missed appointments may be limited to the types of appointments they can book. Patients with outstanding balances may not be able to schedule new appointments until account balances are paid.

Please initial below to let us know you have read and understand our missed appointment policy.

_____ I understand that any changes to my appointment must be made with 24 hours notice as outlined above.

_____ I understand that any missed appointment as outlined above will result in a $40 missed appointment fee.

Contact Lens Policies and Prescription Signed Acknowledgment Form

Contact lens evaluations and fittings are not a part of an annual eye exam, they require additional evaluation and decision making related to how the lenses affect your ocular health. A contact lens prescription is different and separate from a glasses prescription. Contact lens services and supplies are considered an add on to an annual exam and therefore are an additional charge.

The cost of the contact lens evaluation or fitting depends on the complexity of the lens and ranges from $85-175. Payment for contact lens supplies is due when placing the contact lens order.

If you trying a new brand or type of contact lenses, (ie: more than just an update in power) that is considered a refitting. If trying a new contact lens your contact lens prescription can not be released until you return for your scheduled follow up appointment (no additional charge within 60 days).

Visits after a 60 day period may incur a $30 office visit fee. All contact lens service fees are non refundable

Please sign below to acknowledge that you were provided with a copy of your contact lens prescription at the completion of your contact lens fitting and that you are aware contact lenses and **contact lens services are an additional cost to the annual eye exam.**

Signature:_____ Date:_____

(Parent if Patient is a Minor)

The CDC recommends the following for contact lens wearers:

✓ Schedule a visit with your eye doctor at least once a year.

✓ Take out your contacts and call your eye doctor if you have eye pain, discomfort, redness, or blurry vision.

✓ Understand that eye infections that go untreated can lead to eye damage or even blindness.

Symptoms of Eye Infection include:

- Irritated, red eyes
- Worsening pain in or around the eyes—even after contact lens removal
- Light sensitivity
- Sudden blurry vision
- Unusually watery eyes or discharge

The Food and Drug Administration (FDA) indicates:"To be sure that your eyes remain healthy you should not order lenses with a prescription that has expired or stock up on lenses right before the prescription is about to expire. It's safer to be re-checked by your eye care professional."