COLUMBUS EYE ASSOCIATES & COLUMBUS OPTICAL
FINANCIAL/TREATMENT POLICY AGREEMENT
As of 09/22/15

CONTACT INFORMATION. I understand that it is my responsibility to provide and keep Columbus Eye Associates and Columbus Optical up to date with my most current mailing address, home phone number, cell phone number, work phone number, and email address. I understand that this is very important so that I may be contacted with regards to my eye care and my optical eye wear needs.

EMAIL ADDRESS. The email address that you provide below will only be used for purposes such as providing you with patient education; in-office professional notices such as appointment reminders and recalls; newsletters; specials on eye exams and optical goods and services. My Primary Email is _____

REFRACTION. One of the most important parts of your eye exam is the refraction. That is the part of the exam by which we determine whether you can be helped in any way by a new glasses prescription. Refraction refers to how light waves are bent as they pass through your cornea and lens. A refraction assessment helps determine a corrective lens prescription that will give you the sharpest vision. A Doctor or Technician may use a technique called retinoscopy. In this procedure they shine a light into your eye and measure the refractive error by evaluating the movement of the light reflected by your retina. Then they fine-tune this refraction assessment by asking you to look through a Phoroptor, a mask-like device that contains wheels of different lenses and judge which combination gives you the sharpest vision. By repeating this step several times, they are able to find the lenses that give you the greatest possible acuity. It is also how we determine the best possible visual acuity and function of your eye, which is essential medical information to have as we assess your eyes and look for problems. I understand that without the refraction my Doctor may not be able to fully assess the health and function of my eyes. I also understand that most insurance plans consider a refraction a "vision" service not a "medical" service, therefore I understand that a refraction is NOT a covered service by Medicare and most other insurance companies and it is my responsibility to pay for the refraction at the time of service. The fee for the refraction is $30. Unless my plan automatically covers the refraction charge, this fee will be collected at the time of service in addition to any co-payment my plan may require. I accept full financial responsibility for the cost of this service and understand it is due at time of service. I understand that any co-payment, coinsurance or deductible I may have are separate from and not included in the refraction fee.

CONTACT LENS EVALUATION. I understand that if I am contact lens wearing patient, during my Doctor visit a contact lens evaluation may be performed to check the health of my eyes and to look for adverse effects from contact lens wear. I also understand that this may not be a covered service by Medicare, Medicaid, and most other insurance companies. The $20 fee for this service provided by my Columbus Eye Associates Doctor is my responsibility to pay for at the time of service. I also understand that there may be a separate dispensing fee charged by Columbus Optical that may be my responsibility. Why is there a contact lens evaluation fee in addition to the standard eye exam fee? Contact lens patients require additional testing and monitoring over and above what is done during a routine eye exam. Contact lenses are medical devices and even though they may feel fine, there are health risks that must be taken seriously. In order to renew your contact lens prescription, your Doctor may need to perform tests that are not part of a standard eye exam on a yearly basis. The tests that they may perform are:

- Slit lamp microscope examination of the contact lens on the eye to check the lens fit.
- Slit lamp microscope examination of the cornea, conjunctiva and eyelid tissues.
- Contact lens refraction to determine the correct contact lens prescription power (contact lens prescriptions are different than eyeglass prescriptions).
- Review new lens designs and materials that may improve comfort and/or health.
- Corneal topography, a digital color map of the surface of the cornea to monitor shape and curvature, which may be affected by contact lens wear.

**** PARTICIPATING PROVIDER and PARTICIPATING FACILITY LOCATION ****

I understand it is my responsibility to determine if the ***Doctor*** that I receive services from at the ***facility location*** where I received the services at is a participating provider on my network for my insurance. ***I understand that if my insurance plan (HMO, Healthselect, etc) requires referral authorization through my primary care provider directly from the insurance it is my responsibility to request this for my visit(s) to be covered by my insurance.*** It is also my responsibility to always provide the most current copy of my insurance card at each visit. I hereby authorize any insurance company to pay the proceeds of any benefits due me, directly to Columbus Eye Associates and/or Columbus Optical. I also authorize Columbus Eye Associates and/or Columbus Optical to release any information necessary to process this assignment of claim. I understand that Columbus Eye Associates and/or Columbus Optical are obligated to submit my claim information to my insurance company if they are under contract with them.

EXAM CONSENT and FINANCIAL RESPONSIBILITY. I consent to examination and/or treatment of myself or as parent/guardian of the patient named on this form. I acknowledge and understand that I am responsible for all charges for all services rendered to me. Although I may have requested that my Doctor bill my insurance company, I understand that it is my responsibility to make sure that the bill is paid. I understand that if I have Medicare, Medicaid and/or any other insurance company I am financially responsible for payment of exams and/or optical goods that are not a covered benefit.

FORM CHARGES. I understand that there may be a *form charge* for filling out extra forms for insurance companies. If the form is required by a health insurance company or by a state or federal agency for disability etc., I will not be responsible for a *form charge*. However, if the form is for personal use and not associated with an examination, or if it is a life insurance form, or personal disability form, I understand that I will be responsible for the $10 *form charge* per form.

DILATION DROPS. I understand that dilating drops are used to dilate or enlarge the pupils of my eyes to allow the Doctors to get a better view of the inside of my eyes. I understand that dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. I also understand that it is not possible for the Doctors and staff at Columbus Eye Associates to predict how much my vision will be affected. Because driving may be difficult immediately after my examination, I understand that it is best if I make arrangements not to drive myself. I understand that adverse reactions, such as acute angle-closure glaucoma, may be triggered from the dilating drops and that this is extremely rare and is treatable with immediate medical attention. I understand that the eye drops used to dilate or enlarge the pupils of my eyes may be necessary to diagnose my condition; therefore I authorize the Doctors and/or Staff at Columbus Eye Associates to administer dilating eye drops whenever my eyes are examined unless I decline to be dilated.

**** ROUTINE VISION SERVICES VS MEDICAL VISION SERVICES ****

I understand that routine vision services (such as annual eye exams, contact lens exams, contact lens evaluations, frames, lenses, and/or contact lenses, etc) are payable at the time of service, unless there is a vision benefit available on my insurance plan. I also understand that for my eye exams to be a "routine eye exam" I cannot present with any complaint, problem or diagnosis except those relating to receiving a glasses or contact lens prescription (such as nearsightedness, farsightedness, etc).

I understand that if I have been referred to the doctors at Columbus Eye Associates by another doctor for a medical diagnosis, have been previously diagnosed with a medical diagnosis, or during my evaluation the doctor documents a medical diagnosis which might affect the health of my eyes (such as dry eyes, diabetes, hypertension, cataracts, glaucoma, etc) then my eye exams will be considered a medical eye exam <u>not</u> a routine eye exam. I understand that Routine Eye Exams are billable to Vision Insurance Plans, and Medical Eye Exams are billable to Medical Health Insurance Plans.

<u>If I do not have a routine vision insurance plan</u>, I agree to make full payment for my eye exams and optical goods order at the time I place my order. <u>If I have a routine vision insurance plan</u>, I agree to make full payment at the time I receive my eye exams and when I place my optical goods order *for any amount that is considered my responsibility by my vision insurance plan*. If I have a vision benefit available on my vision insurance plan I authorize Columbus Eye Associates and Columbus Optical Company, and their associated Doctors to apply for benefits on my behalf for covered services rendered by them. I also assign my benefits and request that all payments from my vision insurance plan be made directly to Columbus Eye Associates and Columbus Optical Company, and their associated Doctors. I agree to assume responsibility for full payment for any amount that is not covered by my vision insurance plan. I understand that Columbus Eye Associates and Columbus Optical Company, and their associated Doctors cannot guarantee what my vision insurance plan benefits are until my vision insurance plan has processed my claim. As a result, I understand that Columbus Eye Associates and Columbus Optical Company, and their associated Doctors are not responsible for determining what my vision insurance plan benefits are. I understand that it is my responsibility to determine if Columbus Eye Associates and Columbus Optical Company, and their associated Doctors and the facility location where I receive my services or goods are a participating provider on my vision insurance plan and that it is my responsibility to provide to Columbus Eye Associates and Columbus Optical Company, and their associated Doctors my most current copy of my vision insurance card. I understand that Columbus Eye Associates and Columbus Optical Company, and their associated Doctors may be obligated to submit my claim information to my vision insurance plan if they have an agreement with my vision insurance plan. I certify that the information that I have provided to Columbus Eye Associates and Columbus Optical Company, and their associated Doctors with regard to my coverage is correct. I further authorize Columbus Eye Associates and Columbus Optical Company, and their associated Doctors to release to my vision insurance plan and its agents any information related to this or any related claim.

PROTOCOL FOR RESOLVING COMPLAINTS FROM MEDICARE BENEFICIARIES

The patient has the right to freely voice grievances and recommend changes in care or services without fear of reprisal or unreasonable Interruption of services. Service, equipment, and billing complaints will be communicated to management and upper management. These complaints will be documented In the Medicare Beneficiaries Complaint Log, and completed forms will include the patient's name, address, telephone number, a summary of the complaint, the date it was received, the name of' the person receiving he complaint, and a summary of action taken to resolve the complaint. All complaints will be handled in a professional manner. All logged complaints will be investigated, acted upon, and responded to in writing or by telephone by a manager within a reasonable amount of time after the receipt of the complaint. If there is not satisfactory resolution of the complaint, the next level of management will be notified progressively and up to the president or owner of the company. The patient will be informed of this complaint resolution protocol at the times of set-up of service.

Print Patient's Name: _____

Patient's Signature: _____ **Date**: _____

IF ABOVE NAMED PATIENT IS A MINOR,
Print Patient's Parent/Guardian Name: _____

Patient's Parent/Guardian Signature: _____ **Date**: _____