Robins Eyecare

About Your Insurance and Assignment of Benefits

There are two types of insurance to help pay for eye care services and products; vision plans and medical (or health) insurance. The following helps to explain the difference between the two

- Vision Plans
  - Such as VSP and EyeMed
  - Cover routine vision wellness exams, eyeglasses and contact lenses
  - Routine vision wellness exams result in a diagnosis that is refractive in nature including myopia or astigmatism
  - Do not cover medical eye care, or the diagnosis, management, or treatment of eye health problems

- Medical Insurance (Health Insurance)
  - Such as Blue Cross/Blue Shield and Medicare
  - Must be used for medical eye care
  - Medical eye exams result in a diagnosis that is non-refractive in nature such as glaucoma, cataract or dry eye syndrome
  - Used if you have an eye health problem or systemic health problem that has possible ocular complications, including medications you may take that have ocular side effects

You may have one or both of these types of plans. Robins Eyecare accepts most insurance plans in both categories. Your doctor will use your personal medical history to determine the type of exam you may require. If you have both types of insurance plan, it may be necessary for us to bill some services to one plan and some services to the other. We follow a procedure called coordination of benefits to ensure we bill properly and minimize your out-of-pocket expenses.

We will bill your vision plan or medical insurance for services if we are a participating provider for that insurance plan. If we are not a provider, you may submit your own claim for reimbursement of the fees you pay. We will try to obtain authorization in advance for your insurance benefits so we can tell you what is covered. If some fees are not paid by your insurance, we will bill you for them, such as deductibles, co-pays or non-covered services as allowed by the insurance contract.

Please provide your insurance card(s) to our staff member so we can a copy. Having your medical insurance or Medicare card on file ensures we are able to appropriately bill your insurance.

Assignment of Benefits

I assign all of my medical benefits, including all benefits to which I am entitled through Medicare, private insurances, and any other health plans, to **Robins Eyecare**. A photocopy of this assignment is to be considered as valid as an original.

I authorize said assignee to release all information necessary to secure payment of benefits paid and not paid by my insurance company. Benefits quoted to me are not a guarantee of payment by my insurance company, and that final determination can only be made when the claim is processed. **I understand that, if some fees are not paid by my insurance, I am still financially responsible and will be billed for them.**

It is my responsibility to know my own coverage. All known co-payments, deductibles, and charges for non-covered services are **due at the time** that they are rendered.

Patient Name (please print): _____

Patient Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I acknowledge that I received a copy of Robins Eyecare Notice of Privacy Practices.

Date _____ Patient name_____ Signature _____

PHONE MESSAGE CONSENT

From time to time in caring for our patients, it may be necessary or desirable to contact patients by phone. When you are not available for us to speak directly, we like to leave message where possible.

To protect your privacy, we have developed a policy on leaving messages.

- we will not discuss any medical or financial information with anyone except the patient or legal guardian
- we will not leave any medical or financial information on an answering machine
- we will not leave any medical or financial information on a voice mail system
- we will attempt to, as a courtesy, leave a reminder message regarding an upcoming appointment

UNLESS we have your written permission to leave a message for you. Please read the information below and consider carefully whom you want to have access to your medical and/or financial information, such as test results. Please fill out only **one** of the following sections below to make your preferences known.

I **DO** Consent to leave detailed messages:

I give my permission to have detailed phone messages regarding my **medical care** and/or **financial status** (circle medical care or financial status or both) with/on the following:

Initials			
_____	My Spouse	Name	_____
_____	Other	Name	_____
_____	My home phone answering machine / voice mail	Phone #	_____
_____	My work phone voice mail	Phone #	_____

Signature _____ Date: _____

I **DO NOT** Consent to leave detailed messages:

I wish to be contacted personally and do not authorize detailed messages regarding my **medical care** and / or **financial status** (circle medical or financial or both) be left on answering machine, voice mail or with others.

Signature _____ Date: _____