**WELCOME TO VISION DYNAMICS OPTOMETRIC CENTER! We are pleased to have you here – we strive to provide only TOP QUALITY service! We look forward to your positive feedback after your experience with us.**

Your comprehensive annual vision and eye health exam with Drs. Lin / Le / Liu, today includes (but not limited to):

- Refraction (determination of your visual needs for distance, intermediate, near for each eye and both together)
- Ocular health examination of front (anterior segment), middle, and back (retina) of your eyes
- Overall health assessment related to your eyes, medications, vision and referral to specialists if needed
- Glasses and Contact Lens prescriptions to best fit your individual needs – one year warranty on full spectacles
- Thorough education of your conditions, risks, and treatment options
- Personalized attention to your healthy, glasses, contacts, lifestyle, and fashion needs

_____ **OPTOMAP**: **YES**, I choose the Optomap screening option to help detect early signs of retinal disease which can indicate problems such as high blood pressure, diabetes, retinal holes and detachments, for a fee of $39 due today.

____ I request the opportunity to ask my doctor questions and can still do Optomap after my exam, if desired.

☐ **ACCEPTED INSURANCE COVERAGE**: I am aware that my insurance dictates my copay cost due in full today and has a deductible and I am responsible for any portion of my bill that my Insurance Company does not pay for any reason.

☐ **PRIVATE PAY**: Since I have NO INSURANCE or other third parties liable for my visit here, I agree to assume full responsibility and to pay in full at the time services are rendered.

☐ **MEDICARE**: I am eligible for Medicare and understand that it covers my eye exam for health and medical reasons. Medicare does not cover refraction (or measurement of my vision for eyeglass or contact lens prescriptions). I have seen and signed the Medicare ABN form today. Although Vision Dynamics will bill Medicare on my behalf as a courtesy, I am responsible for paying for my services whether Medicare pays or denies these claims. Contact lens service is a separate process & fee. Estimated cost: $45 Required Refraction + $39 Optomap option = $84 due today

☐ **"OTHER" INSURANCE COVERAGE**: If I have coverage by an Insurance Company other than the ones listed as accepted above, I agree to pay Usual & Customary Private Pay fees in full at time services are rendered, accept, and forward the itemized receipt to my Insurance Company for "self-billing" reimbursement. Although I will be exercising my "out-of-nework" benefits, most insurance companies will reimburse me fully or partially, depending on my plan. Vision Dynamics will try to assist me in providing the required codes, but it is ultimately my responsibility to check with my particular Insurance Company for proper reimbursement.

My Insurance Company: _____ Primary Insured Name/DOB: _____ Card provided: Yes / No

☐ **CONTACT LENS EVALUATIONS:** I understand that wearing contact lenses requires additional testing (including, but not limited to bio-microscope evaluation of corneal health and corneal topography mapping) and examination to assure the proper fit and prescription for my safety. Anyone wearing contact lenses, even with little/no changes, will have an associated fee in addition to regular exam fees ranging from $75 to $195 for current wearers and new fits may exceed this amount. It depends on the complexity of my prescription as determined by my doctor and lens fitting/training required and usually covers my contact lens service needs for one year until the following on-time annual exam. Contact lens purchases are final and non-refundable.

☐ **CUSTOM PRESCRIPTION GLASSES**: Since prescription glasses are custom ordered to meet specific individual needs, they are non-refundable. However, we honor and extend a courtesy warranty and re-do's within 90 days for most custom orders. Because we use top quality materials and stand behind our product, we voluntarily extend a warranty on all new frame and lens treatments for one year for normal wear and tear. This warranty is determined fully by the manufacturer and lab and can change at their discretion.

☐ **PATIENT-SUPPLIED FRAME WAIVER**: I understand and accept all risks and expenses for frame breakages or other damage incurred during any procedure performed while completing any repair or request using my supplied frame. Vision Dynamics and its employees or contracted labs/vendors and its employees will not be held responsible.

**COMPREHENSIVE CARE WITH SPECIALIST:** I authorize Vision Dynamics Optometric Center to furnish/request full information and records as requested by accepted insurance companies or designated doctors for purposes of providing you with a clear definition of our financial policy and/or medical consultations to allow us to assist you on important issues of your visual health.

**HIPPAA:** I have reviewed, understood, and agree with the HIPPAA Notice of Privacy Practices. I DO / DO NOT want a copy.

**PATIENT RESPONSIBILTY DISCLOSURE:** Payment is due in full at time of service and before any orders are placed. I am fully responsible for any payments not made by my insurances, and all returned checks shall incur an additional $35 fee.

*Signature:* _____ *Patient Name:* _____ *Date:* _____
*Self / Guardian / other*