Appalachian Eye Care Solutions, Inc.
Andrew Yourich, O.D.
409 Locust Street; Suite 1, Sidman, PA 15955

Thank you for choosing our office as your eye care provider. The following is a statement of our financial policy. Please read carefully prior to any services performed.

REGARDING VISIONCARE & MEDICAL INSURANCE

We often have patients that have both vision insurance (for example, VSP or NVA) and medical insurance (for example, Blue Cross, Aetna, UPMC, or Medicare). They are very different in terms of the services they cover, and it's important for our patients to understand these differences.

Medical insurance is designed to cover you when you have a medical problem, including one that affects your eyes. Medical insurance does not cover routine services or examinations for glasses, or routine vision problems such as nearsightedness, farsightedness, and astigmatism. Those are only covered by your vision insurance.

Vision insurance is designed mainly to cover determining a prescription for glasses, to help pay for glasses or contact lenses, and to cover a yearly routine evaluation of the health of the eyes in a healthy patient that has no particular problems or symptoms. It is not equipped to deal with and does not usually cover medical conditions, injuries, and/or treatments.

When a medical diagnosis or medical condition is present that affects your eyes, such as high blood pressure, high cholesterol, or diabetes, to name just a few examples, or you have an eye disease or eye problem such as an infection, dry eyes, allergy, or cataracts, again, just to name a few, we must file the claim with your **medical insurance**, and the specialist co-pays and deductibles for that insurance will apply. Medical eye health concerns will be addressed initially, if indicated, and a vision exam may need to be rescheduled to coordinate benefits.

There is often no way to know prior to your examination which type of insurance will be the right one to file for your claim. We make every effort to join as many insurance panels, both medical and vision, as we can for your convenience. If we are on your insurance company's panel, we will file those claims for you. In the event that we do not accept your medical or vision insurance, we will provide you with an itemized receipt so that you may file a claim for reimbursement with your insurance company yourself.

Our office does not make these rules, they are made by the insurance companies themselves, and we must comply with them.

I understand the information I've just read about the difference between vision and medical insurance. I authorize Appalachian Eye Care Solutions, Inc. to file my claim with the appropriate insurance based on the reason for my visit and the results of my examination.

_____ Initial

Refraction Policy

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. It is also how we determine the best possible visual acuity and function of your eye, which is essential medical information for us to have as we assess your eyes and look for problems. It is **NOT** a covered service by Medicare and many other insurance plans. These plans consider refraction a “vision” service not a “medical” service. Our office fee for refraction is **$25.00** and unless your plan automatically covers the refraction charge, this fee is collected at the time of service in addition to any specialist co-payment your plan may require.

I have read the above information and understand that the refraction might be a non-covered service with my insurance plan. 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.

_____ Initial

Insurance Signature on File

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits and payment of these benefits to Dr. Andrew Yourich on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release in the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 12 and item 13 of the HCFA-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

_____ Initial

Identification and Proof of Insurance

We must obtain a copy of your driver's license and current valid insurance cards to provide proof of insurance and identification. If you fail to provide the correct insurance information in a timely manner, you will be responsible for payment.

Acknowledgement of Receipt

I acknowledge that I have been informed of the Notice of Privacy Practices for Appalachian Eye Care Solutions, Inc.

_____ Initial (I decline to receive a written copy) _____ Initial (I request a written copy)

HIPAA Authorization

Please list the persons to which we may release information regarding your medical conditions: _____

_____

_____ Initial

Payment Options

Payment in full, for all service fees, is required at date of service. All materials must be paid in full before we will process an order.

We will do everything possible to utilize your insurance benefits. Should services or materials be denied, you will be notified by mail and payment in full is expected within 30 days.

We accept all major credit cards (Discover, Visa, MasterCard, and American Express), Health Savings Accounts (HAS), Flexible Spending Accounts (FSA), Apple Pay and other NFC payments, cash and personal checks.

We currently **do not** accept accounts that are Electronic Benefit Transfer (EBT).

PLEASE NOTE: There will be a **$30.00** charge for any Non-Sufficient Fund checks returned to our office-plus magistrate fees if further collection proceedings are deemed necessary.

_____ Initial

Signature

I HAVE READ AND UNDERSTAND ALL AREAS INITIALED ABOVE. MY SIGNATURE BELOW INDICATES THAT I AGREE TO THESE POLICIES.

Printed Patient Name _____ Signature _____ Date_____

Signature of Parent or Guardian _____ Date_____

(Patient is under 18)