San Leandro Optometry Group
FINANCIAL DISCLAIMERS

Name: _____
This notice applies to the following family members:

PRIVATE POLICY

In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for services, and to conduct healthcare operations involving our office. The Privacy Policy describes these uses and disclosures in detail.
I acknowledge that I have been offered and/or received a copy of the Privacy Policy from *San Leandro Optometry Group.*

_____
Date Signature

FINANCIAL DISCLAIMERS

Eligibility for medical insurance and/or routine vision benefits:
We will attempt to verify your plan eligibility for services and/or materials before your appointment. ***Verification of eligibility is done as a courtesy only and it's not a guarantee of payment.*** Please check with your plan administrator if you have any questions regarding your eligibility. *San Leandro Optometry Group* does not participate in any HMO plans.

_____
INITIALS

Liability
If I have medical insurance or routine vision benefits, I authorize my plan carrier to directly pay *San Leandro Optometry Group*. I also authorize *San Leandro Optometry Group* to release any information required for payment to be made. ***If my plan carrier does not pay, or partially pays, I understand I am responsible for payment in full or the remaining balances.*** My signature below verifies that I understand this agreement and the above financial disclaimers.

_____
Date Signature

CONTACT LENS FEES

Contact lens evaluation services are not an included part of an eye health evaluation and vision assessment, and additional fees apply. Fees are customized according to the complexity of the case and the predicted time necessary to care for the individual patient.
Fees for contact lens evaluation services range from $85 to $400. As with glasses, contact lens materials are an additional fee. My signature below verifies I understand the contact lens fees.

_____
Date Signature

REFRACTION FEE

The part of your evaluation that determines your prescription is called refraction. A refraction is also done under certain circumstances for diagnostic purposes. ***If you have routine vision benefits such as VSP, Eye Med, or Medical Eye Services, your refraction is typically included with your exam benefits. Medical insurances that do not include routine vision benefits, such as Medicare, do not cover refraction. The fee for refraction is $35.*** My signature below verifies I understand the refraction fee.

_____
Date Signature

RETINAL SCREENING FEE (NO DILATION REQUIRED)

San Leandro Optometry Group offers the latest technology in eye examinations; the retinal screening most comprehensive images of your retina. This technology can help detect and document potentially vision threatening and systemic diseases in their early stages like glaucoma, macular degeneration, and diabetic retinopathy. This is not a covered option under most vision benefit plans (such as VSP, EyeMed, and MES). The fee for retinal wellness exam is only $**39 and will be added to your visit today. My initials below indicate that I elect to have a retinal wellness screening ($39).**

_____
INITIALS