# Eye Physicians and Surgeons, S.C.

Mark F. Brower, D.O. Matthew A. Dahlgren, M.D. Daniel J. Solverson, D.O.
Nathan R. Mathews, M.D. Nicholas W. Veith, M.D.


## MEDICAL SERVICE AGREEMENT

I hereby authorize and consent to medical treatment by Eye Physicians & Surgeons, S.C. for me (or my dependent). I authorize Eye Physicians & Surgeons, S.C. to release my (or my dependent's) medical information to my (or my dependent) family doctor and to any insurance company, adjuster, attorney, authorized agent working on behalf of Eye Physicians & Surgeons, S.C. or other authorized party.

I understand that I am responsible for payment of all medical treatment rendered to me (or my dependent) by Eye Physicians & Surgeons, S.C., and I agree to pay all co-payments, deductibles and non-covered services in full at the time of the visit. In the event that I am seen at any time by an Eye Physician & Surgeons, S.C. physician without a required referral, I understand that I am financially responsible for all charges incurred. I understand that insurance authorizations are an estimation of coverage, and that final out of pocket amounts may vary based on actual insurance payment. A fee of $10.00 will be charged for all returned checks.

I understand that during my exam if a medical diagnosis is found, the exam will be considered medical and as such will be submitted to my medical insurance.

I understand that, as a courtesy to me, Eye Physicians & Surgeons, S.C., will file either a paper claim or an electronic claim, whichever is required by my (or my dependent's) insurance carrier, and I authorize payment directly to Eye Physicians & Surgeons, S.C. for the benefits otherwise payable to me under the terms of my (or my dependent's) insurance. I understand that I am responsible for maintaining current coverage information to meet filing deadlines and for the payment of any remaining balance after payment from my insurance carrier. In the event that I fail to meet my financial obligations, I agree to pay attorney and/or collection agency fees in the amount of $10.00 of the amount due at the time the account is turned over for collection plus court costs and any additional collection fees.

I understand that with Medicare as my primary insurance, that I am required to provide my secondary insurance identification card, if applicable. When the office does not have the proper information for a secondary insurance, the secondary will not be billed, and it will be my responsibility to pay the balance, and subsequently file a claim with the secondary for reimbursement on my own.

I understand it is my responsibility to know my insurance benefits and to provide our office with accurate and current insurance information. If my specific insurance plan requires a referral, it is my responsibility to obtain the referral from my primary care physician. If I arrive for an appointment without a referral on file, I have the option to reschedule the appointment or to pay in full for all services rendered at the time of service.

One of the most important parts of your eye exam today is the refraction. This 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 eyes, which is essential information for us to have as we assess your eyes and look for problems, therefore making it a necessary part of the examination and not optional. This is NOT a covered service by Medicare and many other insurance plans. Should your plan pay us for the refraction, we will reimburse you accordingly. The fee for refraction varies year by year.

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Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye. Frequently the drops cause a blurred vision and light sensitivity for a length of time which varies from person to person. It is not possible for your ophthalmologist to predict how much your vision will be affected. Adverse reactions such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention. If you feel like your driving may be impaired, please discuss this with the doctor prior to dilation.

I understand that a medical assistant will accompany the doctor scribing my examination.

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I authorize Eye Physicians & Surgeons, S.C. to view/import my medication history when electronically prescribing medications.

If you are a patient in a hospital or skilled nursing facility, this authorization is in effect for the period of your confinement.

I have been offered and/or received a copy of HIPAA notice of Privacy Practices, and I agree and understand.

Contact lens fittings are additional services and are not included in the cost of your eye exam. Medical insurance does not cover these contact lens related services. All contact lens related follow up appointments within 60 days are included, as are the trial lenses that are dispensed. Contact lens prescriptions are valid for one year by state law. Payment is required at the time of visit.
Standard Contact Fitting - $87.00
Specialty Contact Fitting - $174.00

*All of the above authorizations are in effect until I choose to revoke them.*

_____ _____
Signature Date

_____
Print Name