



**Lawrenceville Family Eyecare  
Insurance and Financial Policy Form**

Please take a few minutes to fill out this form as completely as you can. If you have any questions, it will be a pleasure to assist you.

Patient Name: \_\_\_\_\_ Date of Birth Date: \_\_\_\_\_

Insurance Information: Please provide your vision and medical **insurance card to the doctor's assistant**

**Vision Insurance**

Card Holder's /Member's Name: \_\_\_\_\_ SS#: \_\_\_\_\_

Member's DOB: \_\_\_\_\_ Relation to member: \_\_\_\_\_ Self: \_\_\_\_\_ Spouse: \_\_\_\_\_ Child: \_\_\_\_\_

Employer: \_\_\_\_\_ Vision Ins. Company: \_\_\_\_\_ Group#: \_\_\_\_\_

**Medical Insurance**

Medical Insurance Co. \_\_\_\_\_ ID/Ins. Group#: \_\_\_\_\_

Medicare ID#: \_\_\_\_\_ Secondary INS & ID#: \_\_\_\_\_

**I do not have vision or medical insurance \_\_\_\_\_ (please check if this applies)**

**Please read the following carefully:**

Lawrenceville Family Eyecare will be happy to file your insurance claim for your eye examination. Your claim will be filed to your **vision** insurance if it is **routine** examination. Your claim will be filed to your **medical** insurance if there is a **medical diagnosis**.

**Routine Eye Examinations are defined as:** An examination of the visual system void of any medical eye conditions such as diabetes, glaucoma, macular degeneration, cataracts, allergies or contact lens complications etc.

- **Medical Insurance DOES NOT cover a routine eye examination.**
- **Your medical insurance WILL cover a comprehensive MEDICAL examination IF there is a MEDICAL diagnosis.**
- **Our Comprehensive medical examination fees are based on Medicare fee guidelines**
- **Medical Insurance DOES NOT cover refractions for which there is a \$30.00 fee.**
- **Medical Insurance DOES NOT pay for contact lens fittings.**
- Medicare patients will be required to pay 20% of the examination cost today unless you have supplemental insurance which will cover the balance
- Medical Insurance holders are required to pay appropriate co-pays as agreed upon by your insurance carrier. Please be aware that you must meet your deductible **FIRST** before your medical insurance will pay for services rendered. You will be sent a bill for the balance due if you have not met your deductible.
- If YOUR **medical** or **vision** insurance does not pay for any services rendered, **you will ultimately be responsible for all monies owed. If you fail to pay your bill it will be sent to collections. You agree that you will be responsible for any legal fees associated with paying your bill.**
- By signing below, you understand and agree with all said statements and allow us to file your claim.
- By signing below, I authorize the release of any medical or other information necessary to process this claim.
- I authorize the payment of medical benefits of the undersigned physician or group for services rendered.
- **PROFESSIONAL FEES ARE NOT REFUNDABLE AND ARE DUE AT TIME OF SERVICE.** Contact lens fittings may require a follow-up visit which are subject to additional fees if the patient fails to return within **60 days** of the initial visit.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date