

RICHARDSON EYE ASSOCIATES

660 West Campbell Road, Suite 102

Richardson, TX 75080-3473

Phone (972) 231-3439

Medical Insurance (Including Medicare)

COVERAGE OVERVIEW

Our office is a participating provider with several medical insurance companies including Medicare. Please be aware that medical insurance plans and Medicare DO NOT pay for routine eye examinations. However, if you have any type of medical eye condition (like glaucoma, cataracts, macular degeneration, etc.), and if your health insurance company's rules are met, we may be able to bill your medical insurance carrier for related office visits, special testing, and in some cases the optical materials pertaining to your medical eye condition.

TO OUR MEDICARE PATIENTS

If you are covered by Medicare, please be aware that Medicare will only pay 80% of the charges they approve after you have met the annual \$147 deductible that begins anew each January. You, or your supplemental insurance carrier, are responsible for paying the remaining 20% of the Medicare approved charges and any unmet portion of the \$147 deductible to our office.

EXCEPTIONS / NON-COVERED SERVICES

In addition to any deductibles or co-payments you owe, you are responsible for payment of the following non-covered services to our office:

Refraction - The refraction is the part of the eye exam that either determines your need for a glasses prescription, or updates your glasses prescription. It is an essential part of an eye examination, however, it is not covered by most medical insurance plans, including Medicare. The charge for the refraction is \$37.00.

Contact Lens Evaluation – Patients who wear contact lenses must undergo an evaluation that is in addition to the testing required by a patient who does not wear contact lenses in order to update their contact lens prescription. The charge for this additional testing is \$37.00.

AUTHORIZATION STATEMENT / SIGNATURE

I certify that the information given by me in applying for insurance, co-insurance and/or Medicare benefits is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of such benefits, and I request that payment of these benefits be made on my behalf to my doctor or RICHARDSON EYE ASSOCIATES for services rendered and/or materials furnished. I also authorize my doctor or RICHARDSON EYE ASSOCIATES to release any information needed from my records to the appropriate agency or insurance carrier to determine benefits payable.

I have read and understand the information above and agree to pay for any services or materials I ordered but which are not covered by my insurance carrier including Medicare.

Signed: _____ Date: _____

Print Name: _____