There are two types of health insurance that will help pay for your eye care services and products. You may have both and our practice accepts both:

1. Vision Care Plans (Vision Service Plan – VSP)
2. Medical insurance (Aetna, Anthem, Cigna, Medicare Etc.)

Vision care plans only cover routine vision exams along with eyeglasses and contact lenses. Vision plans only cover a basic screening for eye disease. They do not cover diagnosis, management or treatment of eye diseases.

Medical insurance must be used if you have any eye health problem or systemic health problem that has ocular complications. Your doctor will determine if these conditions apply to you, but some are determined by your case history.

If you have both types of insurance plans it may be necessary for us to bill some services to one plan and other services to the other. We will use coordination of benefits to do this properly and to minimize your out-of-pocket expense.

We will bill your insurance plan for services if we are a participating provider for that plan. If some fees are not paid by your plan, we will bill you for any unpaid deductibles, co-pays or non-covered services as allowed by the insurance contract.

Financial Information and Authorization

Patient Name: _____ Date of Birth: _____ SSN: _____

Employer: _____ Primary Care Physician: _____

If patient is under 18 years of age, please supply the following parent/guardian information

Name: _____ Relationship: _____

Address (if different from patient): _____

_____

Parent/Guardian SSN: _____ Phone #: _____

Payment of Benefits and Responsible Party Statement

I authorize payment of benefits, as determined by my insurer, directly to my Physician. I also understand that I may still be responsible for any balance not paid by my insurance company or vision plan. As the responsible party, I agree that all charges that are not directly paid by my insurance company or vision plan will be my responsibility. I will be responsible for any attorney or collection fees incurred to collect an unpaid balance.

Responsible Party Signature: _____ Date: _____

Consent to Disclose Information

I understand that Brighton Eye Care may use or disclose information about me to bill or receive payment for medical services provided. These disclosures may include releasing information to my health insurance or vision plan, organization, employer, hospital, physician, dentist, pharmacist or entities involved in collecting amounts owed to us.

Responsible Party Signature: _____ Date: _____