Patient Responsibilities and Agreement

MAPLE EYECARE

1. Patient is responsible for payment of Optos photo What is this charge for an Optos photo?

The Optos photo is standard of care at our office. This device has helped identify many ocular conditions during annual eye exams. Optos has aided in preventing partial or complete vision loss. **The cost for this test can range from $0 to $125 depending on insurance coverage.** *(If you opt out, we will need to dilate your eyes)*

I agree to have a retinal image (initial)_____

2. Patient is responsible for payment at time of service

This includes, but is not limited to any copays, out of pocket expenses, deductibles, max benefits, and insurance denials that are sent to us following your appointment.

- **Patients are responsible** for the $65 refraction portion of the exam when medical insurance is needed to be billed. Payment is due at time of service.

- **Ocular health exams for contact lens wearers:** This is an additional part of the eye exam which is subject to additional fees per your insurance plan.

3. Patient is responsible for understanding their insurance information and coverages

We try our absolute hardest to look up and verify your insurance prior to your appointment date, meaning we need proof of insurance provided ahead of time. We require that you provide this information at the time of booking. We are not responsible for payment for out-of-network appointments. We are out of network with Spectera or Davis Vision plans.

4. Cancellation policy: Cancellations within 24 hours of the appointment or no-show are subject to a $50 No-Show Fee

5. Glasses are non-refundable

Our laboratory does not provide refunds for cancelled orders. Glasses are custom medical devices and not refundable.

6. HIPAA Compliance Form

The HIPAA Compliance Form states that we will share your information with insurance companies and select a few other parties where legally necessary but will otherwise keep all your information private and secure.

7. A 3% surcharge is automatically applied to all credit cards. Does not apply for debit/HSA/FSA/cash/checks.

I have read, understood, and agreed to the above terms.

Print Patient Name_____

Signature: _____ Date: _____