Routine Vision Exam or Medical Exam? Please help us bill your correct plan.

Patient: ___________________________  Acct #: ___________________  Date: __________

**Routine Vision (Refractive) Coverage:** Your “vision” plan insurance (VSP, EyeMed, etc.) is intended to provide you with an annual baseline eye exam. Some medical plans also have “wellness vision benefits” as well. **You will need to be aware of your vision insurance benefits and inform us of your coverage.**

**Medical Exams:** If you are symptomatic (itchy, watery, red eyes, flashes, floaters, etc.) during your Routine Vision exam and want the doctor to address your symptoms or a medical problem is diagnosed and you wish the doctor to discuss and treat the condition, we can coordinate your benefits (at your request) and use both plans (vision plan and medical). You may also choose to decline consultation/treatment and return at a later date to address the medical conditions. Medical eye conditions that your doctor may address and treat may include but are not limited to: cataracts; macular degeneration; glaucoma; cornea; retinal problems, dry eyes; ocular allergies.

**How Coordination Works:** If you choose to use coordinate both plans, the medical copay will apply or the vision plan copay (if no copay is required on your medical plan). Your visit will be billed to the medical and vision insurance(s) and subject to your medical deductibles and co-insurance. **You may be billed for any balance remaining after your medical insurance is billed.** You will not be required to pay for your refraction if you choose to coordinate your medical and vision benefits.

**Patient Responsibilities:** You may still be responsible for some co-pays and co-insurance if both insurance billed. Please understand that each patient’s insurance coverage varies and Wohl Eye Center cannot be held responsible for knowing the plan specifics of every patient’s coverage.

To meet your expectations for billing your eye exam today, please indicate the following:

- I am here for a: **Routine Eye Exam _____ (Vision Plan)**  VSP  Eye Med, Cigna Vision , MetLife Vision,
- I am here for a: **Medical Eye Exam _____ (Medical Insurance)**
- I am here for a: **Wellness Vision Exam (covered under my Medical Insurance) _____**
- I authorize **coordination of benefits** if a medical condition is existing, or diagnosed at today’s exam.
  - Yes_______  No_______ (If yes, medical co-pay, co-insurance and deductibles may apply)

________________________________________  _______________________
Patient or Guardian Signature                   Date

Relationship if not signed by patient______________________________