Insurance and other disclosures

How your visit is submitted to insurance. Most insurance plans cover eye exams with a medical diagnosis, and thus are classified as medical visits. The majority of insurance plans (e.g. Medicare), however, do not cover visits for "routine" eye exams. Although it is your responsibility to check with your insurance, as a courtesy, we may call your insurance to verify your benefits. Co-pays, deductibles, and co-insurance may apply to your visit, as determined by your plan.

Refraction fee ($45). "Refraction" means checking your eyes for a glass prescription. As absurd as this may sound, refraction is considered separate from the eye exam by third-party payers. Some plans will cover the fee, many do not. See the Refraction Fee policy.

Vision Plans. Although we do not participate in Vision Plans (e.g. VSP, Davis Vision, EyeMed), most of our patients who have Vision Plans typically use them for glasses and contacts at participating optical stores (call your Vision Plan for participating stores).

Referral authorization. If your insurance requires a referral to see a specialist, it is your responsibility to obtain a referral from your primary care physician prior to your visit with us.

Cancellation and No-Show policy. A fee (posted at the front desk) will be assessed to patients who do not give us at least 24 hour notice of cancellation. If no notice is given by the patient, the appointment will be considered a "no show", more than one of which is subject to dismissal from the practice.

Cell Phone policy. Cell phone conversation is prohibited inside the office. Other use of mobile electronic devices will not be tolerated while being attended by office staff or the physician.

I have read the above policies and disclosures and agree to abide by them. Information, such as appointment reminders, may be sent to me by e-mail and text message. I authorize payment of medical benefits to Fairfield Ophthalmology, LLC, for any services furnished to me by the physician. I authorize the use and disclosure of my protected health information for the purposes treatment, payment, and healthcare operations.

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Signature of Patient/Guardian Date