OSSINING FAMILY OPTOMETRY

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## INSURANCE VERIFICATION

I, _____, authorize Ossining Family Optometry, to bill my health or vision insurance carrier for the payment of my visit. I understand there may be a copayment associated with my visit and that payment is due the same day services are rendered. I acknowledge that it is my responsibility to check my insurance eligibility prior to services being rendered. In the event that my insurance carrier does not cover some or any procedures that were performed during my visit, I agree to pay Ossining Family Optometry, any balance that may result. ***Many insurances do not cover the $30 refraction fee that is charged during a comprehensive exam. This procedure involves the checking of a glasses prescription, It does not include contact lens fees.** I acknowledge the above information as correct, and that I have provided Ossining Family Optometry, with all the information needed to process my insurance claim.

**Insurance Carrier: _____**
**Primary Insured Name:_____ DOB:_____**
**Member ID#:_____**

## CONTACT LENS INFORMATION

[ ] **YES**, I am interested in being fitted for contact lenses [ ] **NO**, I do not want a contact lens exam

Brand:_____

Right Eye:_____ Left Eye:_____

I understand that a contact lens evaluation charge will be applied to my bill for the verification and production of an updated contact lens prescription. Without this contact lens evaluation, I will not be issued a new prescription and may not purchase contact lenses though this practice.

## Dilated Eye Exam Waiver

We are pleased to offer Optomap ultra-wide digital retinal imaging to our patients. The Optomap is the latest in eye care technology and is the recommended method for retinal screening.

The benefits of the Optomap system are:

- ✓ Most patients can avoid having their pupils dilated with drops
- ✓ Testing is fast, easy and comfortable. **Safe for pregnant or nursing women.**
- ✓ Provides a permanent digital record of your retina
- ✓ Enables us to better monitor your eye health annually
- ✓ Continues our commitment to offer all of your patients the highest standard of care available

☐ I elect to have the Optomap ultra-wide digital retinal imaging test performed today. I understand there is an additional $30 fee for this advanced technology which is not covered by my insurance.

☐ I decline to have Optomap ultra-wide digital imaging test performed today, and I understand my eyes will be dilated today to assess my retinal health. I understand I will experience 2-4 hours of blurred vision and light sensitivity with this procedure.

☐ **I DO NOT WANT TO BE DILATED**. I understand that refusing this procedure and not allowing the doctor to examine my ocular health may put me at risk for permanent vision loss.

Signature:_____ Date:_____