TOMASINO GOERSS
VISION SOURCE

Understanding the Patient's Responsibility for Payment

We want to provide you with superior quality eye care during your visit and are happy to provide the courtesy of filing your insurance. However, most insurance plans do not provide 100% coverage for medical/vision services. As the patient, you are responsible for charges incurred at our office that are not covered by insurance including contact lens services, non-covered tests, co-payments, co-insurance and deductibles. It is the patient's responsibility to provide current and active insurance information at the time of service.

To further explain…

As the patient, you sign a contract with your insurance company for a period of time. That contract acknowledges your agreement to pay the co-payment, and any applicable deductible. As a provider, we also sign a contract with insurance companies requiring us to collect any co-pays, or deductible that patients may owe. If either party fails to comply, they will be in violation of the terms of each contract.

Co-payments are a cost sharing agreement in which the patient pays a specified fee at the time services are provided. The medical plan then pays a portion of the remaining cost.

Co-insurance is a cost sharing agreement in which the patient pays a specified percentage of the incurred medical expenses. The medical plan then pays a portion of the remaining percentage.

Deductibles are often a specified amount of expense the patient must pay before the medical insurance plan pays for medical expenses. Deductibles can also apply only to certain medical expenses (ER visits, procedures, etc.).

Medical eye care: Medical insurance can be used for all office visits, testing, and procedures pertaining to a medical problem related to the eyes. Medical Insurance does not cover refraction (vision check). Vision insurance plans cover a routine eye examination with refraction (vision check) and often provide coverage for glasses or contact lens materials. Vision plans do not include the diagnosis and/or treatment of ocular health problems.

Contact lens services: The services related to contact lenses are **not** included as part of a routine eye exam and are **not** fully covered by medical health insurance. These services include the fit and/or evaluation of contact lenses for a patient, trial contact lenses, and all follow-up visits related to the trial contact lenses. Some vision insurance plans do cover a portion of contact lens services and/or give an allowance for purchasing contact lenses.

Non-covered tests: Most all procedures performed by our doctors and technicians are covered by medical or vision insurance. However, there are a few tests performed during a comprehensive eye exam that are not covered by some insurance plans. These tests are often necessary to ensure your complete ocular health. **Please inform our technicians if you would like to discuss any non-covered tests with your doctor before they are performed.**

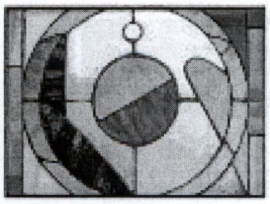
Our office will do all that we can to determine your insurance benefits before and during your visit. Please let us know if we can answer any questions during your visit today. Thank you!

X_____ _____

Signature *Date*

X_____

Print Name



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ACKNOWLEDGMENT
OF
NOTICE OF PRIVACY PRACTICES

The law requires that Tomasino Goerss Vision Source makes every effort to inform you of your rights related to your personal health information. We have copies of our Notice at the front desk that you may request. By signing below, I acknowledge that:

- ☐ I have read or had explained to me Tomasino Goerss Vision Source's Notice of Privacy Practices, and I agree to continue my care with Tomasino Goerss Vision Source under the terms of the policy.

- ☐ I decline the opportunity to read Tomasino Goerss Vision Source's Notice of Privacy Practices but still wish to continue my care with Tomasino Goerss Vision Source under the terms of the policy.

I authorize the release of my Personal Health Information to the following individuals:

Name	Relationship

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____ _____

Patient Date

If you are signing as a personal representative of the patient, please indicate your relationship

_____ _____

Representative Relationship to Patient

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The High Tech Exam

The following tests are highly recommended by your doctor:

The **MPOD** assesses your current risk for developing Macular Degeneration (the leading cause of blindness in adults 65 or older).

The **Optomap** allows the doctor to view up to 80% of your retina without dilating your eyes. This shows the doctor if any defects are present. If a defect is noted, the doctor may recommend returning for a dilated eye examination at a later date.

The **FDT** screens for any neurological and/or glaucoma concerns by analyzing your peripheral field of vision.

These tests utilize the most current technology and are not covered by insurance at this time.

The High Tech Exam for Children (17 and under) is $49 and includes the Optomap and FDT.

The High Tech Exam for Adults (18 and older) is $69 and includes the Optomap, FDT and MPOD.

____ **Yes**, I would like the High Tech Exam today to gain more insight into my ocular health

____ **Yes**, I would like the Optomap only to possibly prevent the need to dilate my eyes

____ **No,** I am not interested in learning more about these options

____ I would like to discuss this further with a technician before deciding

Lifestyle Index

PT INITIALS / ID _____

DATE _____

This questionnaire is meant to help your doctor understand what you're experiencing on a regular basis — whether it's caused by your eyes, posture, stress, etc. Your responses will help make sure you receive the best care possible.

How often do you experience any of these symptoms? Fill in applicable circle. For example: 1 2 3 4 5 ○ ○ ● ○ ○

	1 Never	2 Rarely	3 Sometimes	4 Very Often	5 Always
 **Headaches** of any severity each week, usually getting worse later in the day	○	○	○	○	○
 **Stiffness / pain in neck / shoulders** when you work at a computer or read	○	○	○	○	○
 **Discomfort with Computer Use** in your eyes (redness, burning) after long hours looking at the screen	○	○	○	○	○
 **Tired Eyes** with increasing feeling of eye fatigue throughout the day	○	○	○	○	○
 **Dry Eye Sensation** feeling progressively more gritty/sandy while working at computer or reading	○	○	○	○	○
 **Light Sensitivity** especially with brighter, stronger lights like fluorescents or headlights	○	○	○	○	○
 **Dizziness** or an experience like motion sickness or vertigo	○	○	○	○	○

FOR OFFICE USE

neurolens Value	Prism Split for Order Entry	Misalignment	Mono PD	MQI	AC/A Ratio
	OD:	Near:	OD:	Near:	
	OS:	Distance:	OS:	Distance:	

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