

# Drs. Fine, Hoffman & Sims LLC

Patient: \_\_\_\_\_ Ticket #: \_\_\_\_\_ Date: \_\_\_\_\_

Is this a **Routine Vision** or **Medical** eye examination?

**Routine Vision Coverage:** Your “vision” insurance is intended to provide you with a baseline eye evaluation and update your glasses prescription **only**. If the doctor discovers a medical eye problem during a routine exam, the doctor will finish the routine examination if able, and ask you to return at a later date for the medical exam.

**Medical Eye Examination Coverage:** If you have an eye condition such as but not limited to cataracts, macular degeneration, glaucoma, dry eyes, cornea problems, or a new symptom to be evaluated, this examination will be billed to your medical insurance.

➤ I am here for a: (circle one)    **Routine Vision**                      **Medical Exam**                      **Self Pay-no insurance**

**Notice of Patient Responsibilities:** *Many insurance companies do not pay for a Routine Vision examination. The services provided in a Medical Exam are different from those provided in a Routine Vision Exam. It is your responsibility to contact your insurance carrier for proper coverage and to let us know before your appointment if you are using a Routine Vision benefit or Medical insurance. Drs. Fine, Hoffman & Sims cannot be held responsible for knowing your coverage. We make every effort to bill our services in an ethical manner, which means coding as closely as possible to reflect the intent of the service at the time it was provided. If you request a re-coding of the visit, you are asking us to misrepresent the services we provided. This can be considered fraud. Billing questions can be discussed with our billing department. **By signing below, I understand that I will not be able to change the insurance billing type from Medical to Routine Vision, or Routine Vision to Medical once the exam has been completed. I understand that I am responsible for all charges not covered by my insurance.***

\_\_\_\_\_  
Patient or Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship if not signed by patient

*Thank you for trusting your eye health to us,  
The Staff of Drs. Fine, Hoffman & Sims*