

LevensonEyeAssociates.com | 904-366-3781

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| FINANCIAL POLICY | |
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| Patient Name (please print): | Date of Birth: |
| BALANCES | |
| Your account must be current and prior balances paid be | fore scheduling new appointments. |
| MISSED APPOINTMENT POLICY | |
| keep your appointment but failing to arrive to your allotte | understand that circumstances occasionally arise that do not allow you to d appointment time without sending a cancellation notice AT LEAST 24 may result in a fee of \$35.00. This charge is not covered by your insurance. It services. |
| REFRACTION FEE | |
| Refraction does not include any screening or examination patients. MEDICARE DOES NOT COVER REFRACTION. insurance will deny payment as well. While some insurance | our lenses and aids in the diagnosis and treatment of many eye diseases. n. Federal guidelines require that refraction must be billed separately for all Since Medicare considers this a non-covered service, your supplemental ce plans may recognize and pay for refractions, most do not. Refraction is nt will be expected at the time of service unless coverage and eligibility are |
| CONTACT LENS FITTING FEES | |
| and health for your eyes. The process includes the measurisits for up to eight weeks. After wearing contacts for a prescription is still appropriately pay for these services though some vision plans do provict carrier to verify what coverage you have for contact lens to \$225.00, depending on specific needs/complicity. Renewal | rely fit on your eyes and which lenses provide the best vision, comfort, urement of the eyes; the design and selection of lenses; and follow-up period, your doctor will require a re-examination at least once a year to the and healthy for your eyes. Most of the time, medical insurances do not departial coverage for contact lens services. Check with your insurance services. Our fitting fees for disposable contact lenses range from \$125.00 rewal and refitting fees for disposable contact lenses range from \$95.00 to ervice. No contact lenses will be dispensed prior to the payment of these |
| $\hfill\square$ I have read and understand the policies listed above. | |
| | |
| Patient / Parent or Guardian Signature | Date |