

**KOTECHA EYE & LASER CENTER, PLLC**  
**Capital Vision Policies and Fees**

**Medical Exams:** Patients, who are experiencing a medical eye issue, have had previous eye surgery or have a systemic disease (such as diabetes, Bell's palsy, hypertension, lupus, etc) will require a medical exam which is billed to medical insurance. Medical exams do not include an eyeglass prescription (refraction) or contact lens prescription.

**Routine Vision Eye Exams:** Patients who are experiencing no medical eye issues, have not had previous eye surgery, and/or have no systemic disease, would need a routine vision eye exam. Most medical insurance plans do not cover a routine vision eye exam. Some patients may have a separate insurance for vision. Please note that some insurance requires two separate appointments for medical and vision exams. Additionally, routine vision eye exams do not include a contact lens prescription. As a medical and surgical eye specialist, we do not participate in vision plans. We are happy to provide a receipt for you to apply for out of network benefits.

**Refraction:** Refraction is a test to generate an eyeglass prescription. It is in addition to the medical exam. If the patient requests an eyeglass prescription, a refraction is required. Most medical insurance plans do not cover refraction. The \$90.00 refraction fee is collected at the time of service.

**Contact Lens Evaluation:** A contact lens evaluation is needed to generate a contact lens prescription; it is in addition to the eye exam. If a patient requests a contact lens prescription, a contact lens evaluation is required. Most medical insurance plans do not cover a contact lens evaluation.

**Co-payments/Co-insurance/Deductibles Fees/Non covered and Denied Services:** Patients are responsible for all co-payment, co-insurance, and deductible amounts at the time of service. It is the patient's responsibility to know their insurance benefits. If you have a deductible, an estimate of charges may be collected on the date of your visit. We cannot guarantee that we accept your specific plan as an in-network provider; it is your responsibility to verify your insurance benefits and coverage prior to your visit. If the correct insurance or demographic information was not provided by the patient on the time of the visit, the patient will be responsible for the entire amount owed for services rendered. There will be a \$50 fee on returned checks. I understand that my account will be charged for all fees not covered by my insurance for any reason. In the case of an account overpayment, the credit will remain on your account unless you request otherwise.

**Collections:** All balances beyond 90 days past due will be sent to our collection agency. You will be financially responsible for collection fees of 28% and all legal fees that our office incurs to collect the outstanding delinquent balance.

**Referrals:** If a referral is required by your insurance, it is the patient's responsibility to have this referral at the time of their appointment to avoid being rescheduled and to avoid being responsible for fees.

**Cancellations & No-show:** Patients who do not cancel or reschedule their appointment at least 24 hours in advance will be charged a \$50.00 fee. There is a fee of \$150 for any surgery or procedure that is cancelled or rescheduled in less than 72 hours of the surgery appointment.

**Records:** All medical record requests must be received in writing. There is a \$35.00 fee for release of medical records.

**Forms/Letters:** Any forms or letters to be completed/dictated by our staff are not covered by insurance and are subject to a \$25.00 administrative fee. There is a \$80 fee for DMV forms and visual fields test if no medical reason for visit. Personal letters or written certificate for medical cannabis for appropriate diagnosis is \$80 for initial certificate and \$50 for annual renewal.

**Medication Refills:** Please request medication refills during your appointment time or a fee may apply.

**Notice of Privacy Practices:** By signing below, the patient (or legal guardian) has acknowledged that they have reviewed the Notice of Privacy Practices and the Policies and Fees. I understand and accept all terms and conditions of my examination and the financial policy.

I authorize Kotecha Eye & Laser center to apply for benefits on my behalf for services rendered and request that insurance payments be made directly to them.

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Patient/Legal Guardian Signature

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Patient/Legal Guardian Name

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Date