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, may 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. Additionally, routine vision eye exams do not include a contact lens prescription. If a patient has no medical diagnosis warranting a medical exam, but elected to have a routine vision examination, the patient will be charged a self-pay price of $190.

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, refraction is required. Most medical insurance plans do not cover refraction. The **$105.00 refraction fee** is collected at the time of service. We are unable to provide expired prescriptions to patients.

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 the patient has a deductible, an estimate of charges may be collected on the date of the patient's 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. The patient understands that their account will be charged for all fees not covered by insurance for any reason. In the case of an account overpayment, the credit will remain in the patient's account unless the patient requests otherwise. If no request is made, refund checks will be issued annually.

Collections: All balances beyond 90 days past due will be sent to our collection agency. The patient will be financially responsible for collection fees of 28% and all legal fees that our office incurs to collect the outstanding delinquent balance. Accounts not paid within 90 days of the final billing date may be subject to a finance charge not exceeding 3% annually on the outstanding balance.

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 that is cancelled or rescheduled in less than 1 week prior to a surgery appointment.

Communications: The patient consents to receive text messages from our office regarding appointment reminders, scheduling updates, outstanding balances, and other administrative matters. Standard message and data rates may apply. The patient may opt out of text communications at any time by notifying our office.

Records: All medical record requests must be received in writing. There is a flat $20.00 handling fee for medical records and a $0.50 charge per page up to 50 pages. For any additional pages over 50, the patient will be charged $0.25 per page.

Forms/Letters: Any forms or letters to be completed/dictated by our staff are not covered by insurance and are subject to a $35.00 administrative fee. There is a $80 fee for DMV forms and visual fields test if no medical reason for visit.

Medication Refills: Kindly request medication refills at the time of appointment if possible. If the patient needs a refill, the office must be contacted prior to the last refill order.

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. The patent understands and accepts all terms and conditions of the 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.

_____	_____	_____
Patient/Legal Guardian Signature	Patient/Legal Guardian Name	Date