C&S Optometric Services
dba New Bern Family Eye Care
dba Pamlico Family Eye Care

Patient Name:_____ **DOB:**_____

Patient/Guardian Social: _____ **Guardian Name:** _____

ACKNOWLEDGEMENT OF PRIVACY POLICIES (HIPPA)

I acknowledge that I have been educated on and offered a copy of this office's Notice of Privacy Policies.

Patient/Guardian Signature:_____ Date:_____

INSURANCE AUTHORIZATION

I request that payment of authorized insurance benefits for any services furnished to me, be made on my behalf to C&S Optometric Services, PLLC. I authorize C&S Optometric Services, PLLC to release any medical records about me to my insurance company that may aid in determining benefits or payment. **I understand that I am responsible for charges not paid by the insurance plan.**

Patient/Guardian Signature:_____ Date:_____

ADVANCED BENEFICIARY NOTICE (ABN)

Non-covered services:
By signing below, I acknowledge I have been notified by my physician that the services identified may not be covered for reasons stated. I agree to be personally and fully responsible for payment. I understand that my doctor may order (more in depth versions of) these tests if medically necessary.

REFRACTION (Process by which glasses and contact lenses are prescribed as part of a regular eye examination) **not considered medically necessary by Medicare and other medical insurance carriers**
FEE: $44.00 (This fee reflects a 20% time of service discount)

Patient/Guardian Signature:_____ Date: _____

OPTOMAP RETINAL EXAM (Comprehensive digital images of the retina which help evaluate ocular health) **not deemed necessary without supporting medical diagnosis**
FEE: $40.00

Patient/Guardian Signature:_____ Date: _____

(Due to the increased risk of eye disease in patients over age 50, an Optical Coherence Tomography (OCT) will also be performed as part of this screening. This scan can help diagnose glaucoma, macular degeneration, and other diseases of the optic nerve.)

CONTACT LENS YEARLY EVAULATION (Difference in general exam and contact lens exam that insurance companies consider cosmetic. New patients must present their most current contact lens prescription to avoid paying additional fitting fees. Patients have 60 days to finalize their contact lens prescription to prevent an additional evaluation cost.)
FEE: $51.00-$60.00

Patient/Guardian Signature:_____ Date: _____