Insurance Information

We want to inform you that often, we need to file your eye exam on your medical insurance rather than your vision insurance due to medical necessity. Any eye condition that you have other than simply needing glasses or contacts will initiate a medical necessity. Medical conditions include but are not limited to: dry eye, allergies or conjunctivitis, cataracts, glaucoma/glaucoma suspect, freckles on the eyelid/iris/retina, disorders of accommodation, vertical or horizontal misalignment of the eyes, etc. Your vision insurance can still be used for glasses and contact lens purchases. It is our goal here at Scasta Family Eye Care to provide you with the highest quality eye care, and we thank you for allowing us to do that.

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly Tracey Scasta, O.D. all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

By signing this statement, I understand that my vision and/or health insurance is a contract between myself and my insurance company. Although Dr. Scasta and staff have made every effort to verify my benefits before my appointment, no guarantee can be made that the information received is accurate since incorrect information may be provided by my insurance company from time to time. I understand that it is ultimately my responsibility as the patient to understand my vision and/or health insurance coverage as well as handle any charges my plan does not cover.

I understand that I am financially responsible for all charges whether or not paid by insurance.

Patient or Guardian Signature: ___________________________________ Date: ___________________

Notice of Privacy Practices (laminated sheet below)

I acknowledge that I have read and understand the Notice of Privacy Practices as implemented by Tracey Scasta, O.D., I am aware that I may request a copy of this agreement for my personal records.

Patient or Guardian Signature: __________________________________ Date: ___________________

Release of Identifying Health Information

I authorize Scasta Family Eye Care to release health information (including, if applicable, information about substance abuse, mental health conditions, and HIV infection or AIDS) about me including billing and/or insurance information to the following person (for example, parent, spouse, sibling, etc.)

Person to whom the information may be released: ____________________________________

Relationship to you: ______________________________________

Patient or Guardian Signature: __________________________________ Date: ___________________