Individual Patient Insurance Information

305 Dakota Dunes Blvd. • Dakota Dunes, SD 57049 • (605) 232-6900 • duneseye.com

Thank you for choosing Dunes Eye Consultants for your eye and vision care needs. The primary objective of our clinic is to preserve and protect your gift of sight. This is our standard of care. We accomplish this by using the best technology combined with highly trained staff and doctors who provide patient centered state-of-the-art care.

Government regulations along with insurance payer rules are continuing to change with stringent objectives. These objectives must be met to remain in compliance with new and existing health insurance contracts. As a courtesy to you, we will research your insurance benefits to help assist you in making informed decisions about your care. **This information provided to us by your insurance company is NOT a guarantee of payment. Dunes Eye Consultants agrees to the contracted fee schedules set by your insurance company. On occasion this will result in billable fees that will be your responsibility to pay. Payment in full will be due on date of service.** *See next page of this form for conditions and symptoms that apply for medical eye coverage and check all that apply.*

If options with your coverage allow, please choose one of the following to indicate your preference. Please not that we will always strive to honor your preference when your benefits allow.

Medical Insurance Options:

A. If option, I wish to use my medical vision wellness benefit with an office co-pay. Co-pay as quoted by my insurance company is $ _____ . If there is a variation of this benefit, the details will be presented.

B. I wish to use my primary medical insurance for my visit today because I was instructed to return for monitoring my eye health conditions or I have a new symptom/ medical condition that requires evaluation. Fees charged are in accordance with my insurance plan. Office co-pays range from $0 to $90. I am required to pay the co-pay and any deductible amounts that have not been satisfied which apply to my evaluation today as quoted by my insurance plan. Copay/Co-insurance quoted by my insurance is $ _____ .

Managed Vision Care Plan Options:

A. I wish to use my managed vision care plan benefits plus additional diagnostic screenings: retinal screening (OPTOS) $39 plus pathology screening $20. This $59 diagnostic screening fee is in addition to your examination copay. Expect to pay $59 to $89 for this level of care. Expected Pt Fee:_____

B. I do not wish to have any additional technology testing and wish to use my managed care benefit for a routine vision evaluation only. I will be dilated and understand this service level is not consistent with the recommended level of care advised by this clinic. Any identified medical eye diagnosis, symptom or conditions will require a separate additional office appointment, billed to my medical insurance or paid out of pocket. Expect to pay a co-pay of 0 to $30 for this level of care. Expected Pt Fee: _____

Cash Pay Options:

A. I wish to pay cash for the services received today with an administrative discount off the usual/customary fees.

I am aware that additional diagnostic tests may be indicated for documenting medical eye conditions to aid in the management, treatment or protection of my vision during this evaluation. I will be informed of these costs prior to the care being provided. I agree that I will be responsible to pay these fees indicated at the time of checkout. I also accept responsibility for and will pay any out-of-pocket fees extended beyond my co-pay and applicable deductible that applies to the visit I have selected.

PATIENT SIGNATURE _____ DATE _____

Dunes Eye CONSULTANTS | Dunes LASIK CENTER

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Systemic health conditions indicating need for a medical eye exam:

- ❍ Headaches of any type
- ❍ Diabetes
- ❍ Poorly controlled hypertension
- ❍ Arterial sclerosis
- ❍ Rheumatoid arthritis
- ❍ Graves disease: hyperactive thyroid
- ❍ Multiple sclerosis
- ❍ Sickle cell disease
- ❍ AIDS
- ❍ Any autoimmune disease
- ❍ Patients using high-risk medication, oral steroids, Plaquenil

Eye conditions prompting need for medical eye exam:

- ❍ Cataracts
- ❍ Glaucoma
- ❍ Macular degeneration
- ❍ Allergies
- ❍ Blepharitis
- ❍ Floaters
- ❍ Flashes and floaters
- ❍ Eye fatigue and headaches
- ❍ Red eyes
- ❍ Blurred vision
- ❍ Increased light sensitivity
- ❍ Previous uveitis
- ❍ High eye pressure/ocular hypertension
- ❍ Family history of glaucoma
- ❍ Peripheral degeneration of the retina
- ❍ Contact lens associated conjunctivitis
- ❍ Bumps or lumps along the eyelid margin
- ❍ Droopy eyelids
- ❍ Keratoconus
- ❍ Dry eyes

Visual or eye symptoms prompting need for medical eye examination:

- ❍ Glare at night
- ❍ Halos around lights
- ❍ Morning crust along eyelids
- ❍ Red eyes
- ❍ Itchy eyes
- ❍ Fluctuating
- ❍ Blurred vision not corrected with current glasses or contacts
- ❍ Headaches and eye fatigue
- ❍ Double vision
- ❍ Ghosting of vision
- ❍ Vision improved by blinking
- ❍ Pain around eyes
- ❍ Irritation around eyelid
- ❍ Gradual loss of vision
- ❍ Flashes and floaters
- ❍ Intolerance to contact lens
- ❍ Twitching eyelid
- ❍ Lights in vision that last 15-20 minutes
- ❍ Pain on eye movement
- ❍ Pain behind the eye
- ❍ Change in color vision
- ❍ Sudden distortion

❍ I am not experiencing any of the above symptoms or conditions.

Date _____