OMNI VISION
FINANCIAL & INSURANCE POLICIES

OUR FINANCIAL POLICIES ARE AS FOLLOWS:

1. All fees for professional services are due in full the day services are rendered.
2. Professional fees and/or contact lens fitting fees are not refundable.
3. *Emergency medical visits* are to be paid in full the day services are rendered. Our office will be happy to file your medical insurance. However, you will be responsible for all fees if your insurance company decides not to pay for your visit for any reason.
4. *Fees for eyewear/contact lenses* are as follows:
   - For those patients with vision insurance: all co-pays are due in full. Overages are due in full prior to ordering the eyewear/contact lenses.
   - Patients with no vision insurance must pay the entire professional fitting fee prior to fitting contacts. All material fees are due in full prior to ordering the eyewear/contact lenses.
   - ALL first time contact lens wearers are required to practice Insertion & Removal (I&R) skills with us. There is an additional fee of $20 for this I&R class.
   - Telephone replacement orders must be paid in full prior to ordering.
5. *Credits:*
   - There are no refunds on eyewear/contact lenses.
   - Glasses and contacts orders cannot be cancelled or modified after your insurance is submitted and/or the lab has started creating your orders. Your glasses or contact lenses are considered as medical devices. They can't be reused for others once they are prepared.
   - Credits can only be issued during the first 30 days after dispensing of the eyewear/contact lenses. The eyewear/contacts lenses must be returned undamaged. Boxes of disposable contacts must be returned unopened and undamaged.
   - Credits can be used for any individual and never expire.
6. *Warranty:*
   - Eyewear: You have an option to purchase a $35 eyewear warranty. This has to be purchased on the same day you purchase your eyewear. It is a *one-time* warranty in *one year* for your frame and/or lenses due to manufacturer defect, including scratches. The frame/lenses will be substituted with the exact same prescription, style, and color. Gross negligence or loss is not covered under this warranty. Glued frames are not covered under this warranty. This warranty cannot be transferred to a different patient/frame/lenses. All parts of the broken frames/lenses must be returned to the office.
   - Contact Lenses: we offer a 30-day warranty on all fitting types. Multiple visits might be necessary to provide good comfort and vision. A new professional fitting fee will be applied if you decide to come back with any contact lens problem after 30 days from the initial fitting date.
7. *Other:*
   - All orders for your eyewear/contact lenses must be picked up within 30 days of notification. Failure to do so will result in the forfeiture of your payment and your eyewear/contact lenses will be donated to charity.
   - In the event you are not happy with the frame you have picked out for yourself, we are more than happy to re-frame you with a new frame. There will be a restocking fee of $50. This can only be done within 30 days after dispensing of your eyewear. If the new frame costs more than the old frame, you are responsible for the difference.
   - In the event you want to add other add-ons (such as anti-glare, transition, etc.) to your lenses after the purchase, you are responsible for paying for entirely new lenses.

OUR INSURANCE POLICIES ARE AS FOLLOWS (IF YOU HAVE INSURANCE):

Omni Vision wants to make sure your insurance carrier pays for your eye exam; therefore, we must file your exam to the appropriate insurance. The main reason of your visit will determine which type of insurance our office will file. It is important for you to understand the two different types of eye examinations/insurance: VISION vs. MEDICAL. Omni Vision does not make up these rules.

Your MEDICAL INSURANCE (and its copay/deductible will apply) will be filed when:

- The reason for your visit is either itchy eyes, dry eye, red eyes, pink eyes, or teary eyes AND treatment is initiated
- You come to our office due to a foreign body in the eye
- You want a cataracts evaluation/treatment
- You want a glaucoma evaluation/treatment
- You or your Family Doctor wants a diabetic eye examination
- You have macula degeneration
- You have a lazy eye or amblyopia
- There is an eye condition prevents you from seeing well even with glasses/contacts

Your VISION INSURANCE (and its copay will apply) will be filed when:

- You only want an exam for a glasses/contacts prescription
- Blurred vision at distance and/or near is purely due to the need of wearing glasses
- A yearly wellness or routine eye exam in the absence of any eye disease

1. I certify that I, and/or my dependent(s), have insurance coverage and assign directly to Omni Vision all benefits for services rendered. Omni Vision DOES NOT guarantee that my insurance will pay my claim even if benefits are verified before the appointment. I will be responsible for all the charges if my insurance does not pay for my services.
2. I further expressly agree & acknowledge that my signature on this document authorizes Omni Vision to submit claims for services rendered without obtaining my signature on each and every claim to be submitted for the same date of service for myself and/or my dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim dated today or in the future until further notice has been expressed in writing.
3. Omni Vision may use my health care information and may disclose such information to the insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or benefits payable for related services.

I have read and fully understood the FINANCIAL & INSURANCE POLICIES statement. I will be responsible for all fees if my insurance decides not to cover for the visit, regardless prior authorizations. Also, I understand that if I have any question about my insurance benefits, I am able to speak to an associate who can answer my questions prior to seeing the doctor.

PATIENT NAME: _____ DATE: _____

GUARDIAN NAME (if patient is <18 years old): _____

SIGNATURE: _____

THESE POLICIES ARE NECESSARY IN ORDER TO CONTINUE TO RENDER THE QUALITY SERVICE TO WHICH YOU ARE ACCUSTOMED.
WE VALUE YOUR BUSINESS AND HOPE TO CONTINUE TO SERVE YOUR EYECARE NEEDS.