Contact Lens Examination

This exam is *not* part of a regular eye exam.

I would like to have a contact len examination today in order to update my contact lens prescription to order more replacement lenses. **The fee will range $40.00 to $130.00**

___ $40 and up Standard Soft Distance vision only, no Astigmatism

___ $60 and UP Astigmatism/Toric Contact Lens /RGP

___ $60 and UP Multifocal-Bifocal Contact. Customized Monovision (correction of distance and near vision)

___ $130 and UP CRT RENEWAL

___ I am not a contact lens wearer but I want to talk to the doctor about contact lenses Dr will discuss fees in exam room

The fee for a "new fit" (never worn contact lenses) contact lens examination ranges from $130.00 and UP (depending on the complexity).

____ I am not a contact lens patient and I am not interested
Zero additional fees

___ I am a contact lens patient and I do NOT want my prescription updated today. I understand I will NOT be able to order any more contact lenses.

A contact lens examination is necessary if you need a renewal of your contact lens prescription for ordering more replacement lenses.

_____ _____
Patient/Parent Signature **Date**

_____
Patient Name Printed

Beyer Eye Associates

I _____ understand that I am expected to know my insurance coverage at the time of service. If a referral is required with my insurance and I do not have one, I will be responsible for the charges incurred during my visit.

I hereby authorize and guarantee payment for all services rendered. Although fees for services are due and payment is expected at the time services are rendered, if I have been granted a grace period for payment of fees, I acknowledge that payment is due and expected at the time my billing statement is received.

In the event that my account becomes delinquent for more than 30 days, I also agree to pay a finance charge of 1.5% per month on any balance as well as all reasonable collection costs not to exceed 50%, court costs, attorney fees and interest fees accrued with the collection of this account.

If you have a vision plan (VSP, EYEMED, DAVIS, VBA) it is imperative that you notify the front desk staff upon arrival to alleviate any errors that could occur with billing. Beyer Eye Associates will not alter or be responsible for any billing information after the date of service

Some insurance plans such as Medicare do not pay for refractive services. This is the part of your eye exam that determines your prescription and best corrected vision. The AMA (American Medical Association) mandates separate billing code (92015) is used for this portion. If is is not payable/covered you are responsible for payment. Any questions may be directed to our staff.

We have taken necessary safety precautions for each patient's visit for COVID 19. Due to the additional time to implement these safety precautions and reduced patient volume to ensure your safety it's important to keep your scheduled appointment. We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment.

If an appointment is not cancelled least 24 hours in advance a $50 no show fee will be charged to your account. This will not be covered by your insurance

_____ Date:_____

Responsible party signature

_____ _____

Printed Name of Patient Printed Name of Parent/Guardian

Mercerville	Millstone	Newtown
395 Route 33	498 Monmouth Rd	11 Friends Lane
Mercerville NJ 08619	Clarksburg,NJ 08510	Newtown PA

Patient name Date

I understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. I further understand that COVID-19 is contagious and is believed to spread by person-to-person contact, and as a result, federal and state health agencies recommend social distancing. I understand that my doctor has put in place reasonable safety measures to help reduce the spread of COVID-19. I understand the potential risks and wish to proceed with my exam.

Patient COVID 19 Disclosure Form

1. Do you currently have a fever above 100.0, cough, difficulty breathing, shortness of breath,sore throat. YES / NO
2. Have you been diagnosed with COVID 19 in the past month. YES / NO
3. Are you currently being tested for COVID 19 YES / NO

   If tested what was Result : Positive / Negative
4. Anyone at home sick, quarantined, or being tested for Covid 19 YES / NO.

Patient Signature

If you answered yes to any of the above we kindly ask you to reschedule.

Employee only

Temperature:

If 100.0 or above please kindly ask patient to reschedule.

Employee initial_____

OPTOMAP Digital Retinal Scan

During COVID 19 we recommend an Optos exam to decrease wait time, exam time, congregation in waiting rooms and less close interaction during the exam to maximize social distancing

Beyer Eye Associates offers state of the art digital scanning technology that allows our doctors to view the inside of your eye *without* the use of dilation drops. The OPTOMAP allows our doctors to evaluate your retina for problems such as macular degeneration, glaucoma, retinal holes, retinal detachments, hypertensive and diabetic retinopathy and much more. The scanning system is completely safe for both kids and adults and allows you the opportunity to see the inside of your eyes just as the doctor sees it.

Dilated Exam	**VS**	**Optomap Exam**
***exam time 30-60 mins** **Drops take 20-30 mins to work**		***exam time typically under 15 mins**
1. Blurred near vision for 4 to 6 hours 2. Light sensitivity for 4 to 6 hours 3. Longer office visit to wait for drops to take effect 4. Only the doctor can see the retina		1. No blurred vision 2. No light sensitivity 3. Scan takes less than 1 minute 4. Digital images are reviewed and Compared each year. 5. YOU CAN SEE YOUR RETINA

Our doctors recommend that all patients have a thorough examination of their retina each year. There is an additional fee of ***$39.00*** for the OPTOMAP scan due on the date of service. In most cases, this scan is not covered by insurance. Dilation may still be required on occasions.

_____ I elect to have a digital scan of my retina today ($39.00)

_____ I prefer a dilated exam of my retina. (no additional fee)

_____ _____

Patient/Guardian Signature Date

Patient Name_____