

110 N. Adelaide
Terrell, TX 75160
(972)563-3253
(formerly Family Vision Center)



1830 S. Buckner Blvd.
Dallas, TX 75217
(214)398-1144
(formerly Grove Eye Clinic)

OFFICE POLICY

A. Financial Policy

a. Payment for all professional services is due at the time the services are provided.

b. We submit insurance claims as a courtesy to you. All copayments and non-covered services are due at the time of the appointment. All benefits quoted are not a guarantee of payment by your insurance company and final determination can only be made when the claim is processed. Any expenses not paid by the insurance company become the responsibility of the patient or responsible party.

1. *Vision Insurance* plans cover routine vision exams along with a portion of eyeglasses and/or contact lenses. Vision plans only cover a routine eye exam. They do not cover diagnosis, management, or treatment of eye diseases.

2. *Medical Insurance* must be used if you have any eye health problem or systemic health problem that has ocular complications.

c. It is your responsibility to provide Blink Vision Center with your current insurance card and a picture identification (ID) card, i.e. current driver's license, state ID card, or student ID (18 and over), at the time services are rendered. If you provide incorrect or expired insurance information, you will assume full financial responsibility for all charges incurred.

d. Some HMO insurance companies require a referral from your primary care doctor before services are rendered. It is your responsibility to obtain a valid referral. If you do not have a referral, and your insurance company denies the claim, you will be financially responsible for all charges incurred.

e. **Assignment of Benefits:** I hereby authorize my insurance benefits be paid directly to Lindsey Alexander O.D., P.A. I understand I am responsible to pay all non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers and/or specialists referred to by the physician.

Signature of Responsible Party

Date: _____

Printed name of Responsible Party

B. Refraction Services and Fees

Refraction is a test to determine how well your vision can be corrected and your overall visual function. It is an essential part of an eye exam and necessary to write a prescription for glasses and contact lenses. Most medical insurance plans, including Medicare, do NOT cover routine refractions. The refraction fee at Blink Vision Center is \$48.00. Any non-covered expenses not paid by the insurance company may become the responsibility of the patient or responsible party.

C. Contact Lens Exam Policy

Contact lenses are considered medical devices. Therefore, evaluations require additional procedures and fees that are not part of, or in addition to, the routine exam and refraction. A contact lens evaluation includes initial fit, all disposable trial lenses, and follow-up care related to the contact lenses for one month. Any visit after that will incur an additional charge. Once we have determined the type of contacts you are comfortable with, an order will be placed requiring a 50% deposit. If for some reason your contacts do not work out after they have been finalized and they were purchased from Blink Vision Center, you may return unopened, non-expired, and unmarked contact lens boxes for a credit or exchange within 45 days from the date they were purchased. Professional services are non-refundable.

D. Eyewear Policy

a. We require a 50% deposit on all orders and the balance must be paid before eyewear is dispensed. Prescription glasses and contact lenses are special order items and once ordered, cannot be cancelled. Our office staff will do everything we can to ensure you are pleased with your eyewear; however, due to the time involved and custom nature of your new eyewear, **all sales are final**.

b. Frames – If your frame breaks under **normal** wearing conditions, we will repair or replace them **one time only within one year from the date of purchase** for \$10.50 which covers the postage to return the broken frame to the manufacturer. Please note the following will **void the warranty**: ALL broken frame parts are not accounted for, you have attempted to glue your broken frame (there can be no signs of glue anywhere on the frame), they have been chewed by your feisty pet, or look like they have been run over by a truck. Unfortunately, we do not cover loss, theft, or abuse of your frames. Be advised, if you decide to order a different frame, your old lenses will not fit in them and will need to be reordered. Any cost of new lenses not covered by insurance becomes the responsibility of the patient.

c. Lenses – Our lens treatments provide the most reliable and durable surface protection available. However, any lens can scratch or break. With our warranty, your lenses can be replaced due to scratches or coating defects once within one year from the date of purchase. Lens replacement must be the original prescription and you must surrender the defective pair. Warranty does not apply to plastic lenses or lenses with basic anti-reflective coating.

EYEGLOSS WARNING: Standard plastic and glass lenses can shatter in high impact situations and can cause damage to your face or eyes. We always recommend impact resistant lenses such as polycarbonate or trivex.

d. Providing your own frames – We will be happy to make prescription lenses if you choose to bring your own frames. Due to the unknown history of the frame, Blink Vision Center is not responsible for any damage that may occur during shipping, lens insertion, or if the frame is lost in the mail or by the lab.

e. You will be contacted by text or telephone when your eyewear products are available. Due to our limited space, please pick up ASAP. Several attempts will be made to contact you, however, after 60 days, if the products have not been picked up, they will be returned to stock (lenses will be placed in your file) and you will lose your deposit.

E. Minors (complete if applicable)

a. By signing for a minor on all paperwork associated with Blink Vision Center, you must attest that you have legal authority to make medical decisions for the child/children. If you cannot attest to this, unfortunately, we will not be able to provide care for the minor(s).

b. I hereby attest I have legal authority to make medical decisions for the below named minor(s).

_____	_____
_____	_____
_____	_____

Parent/Guardian: _____
(Please Print)

Signature: _____ Date: _____

F. Pupillary Distance Measurement

Measuring your pupillary distance (PD) is not a routine part of an eye exam and is generally not performed by an eye doctor. It is part of the dispenser’s scope of practice (the person who is interpreting the prescription and designing the eventual glasses). This measurement is taken in the doctor’s office, becomes part of your medical record, and will be released upon your request. If you are not purchasing eyewear at our practice, the measurement will not be taken. However, if the measurement is requested by the patient, it is considered an additional service and a fee of \$25 will be charged.

G. Missed Appointments

a. We understand there are times when you must miss an appointment due to emergencies or obligation 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.

b. We have a very large waiting list of patients who can fill canceled or rescheduled appointments if our staff is notified in a timely manner. Please be courteous and call our office ASAP but at least 24 hours prior to your appointment if you need to cancel and reschedule. Patients who do NOT contact us within this timeframe will be assessed a \$30 "No Show" fee per family member who had an appointment.

c. Our doctors are very generous with time spent with their patients and, for the convenience of large families, make every effort to see all family members at one time on the same date. Since we have experienced multiple "No Shows" of large families with back-to-back appointments, we, unfortunately, must limit the number of family members per visit to three. Therefore, large families will have to make more than one appointment on a different day if there are more than three family members who need to be seen by a doctor.....unless prior approval has been given.

I have read and understand Blink Vision Center's entire Office Policy as stated above and I agree to its terms. I also agree that such terms may be amended by Blink Vision Center at any time.

_____ Date: _____
Signature of Responsible Party

Printed Name of Responsible Party

Blink Vision Center is dedicated to providing the ultimate in quality care, courtesy, service, and products to our patients. Thank you for allowing us to assist with your eye care needs!