TO OUR MEDICARE/PRIVATE INSURANCE PATIENT

Medicare/Private Insurance will cover the cost of your doctor's visit today if you are seen for a medically based eye examination. Medicare/Private Insurance does not cover the cost of routine eye care. Please understand that routine eye care is not a benefit of Medicare/Private Insurance. The medically based eye examination is extensive. It is a thorough exam which usually includes additional testing not included in the routine eye examination. In addition, counseling may be provided to you or treatment may be prescribed for you by the doctor. The doctor will determine the need for such an examination, and you may discuss the determining factors with the doctor at any time.

We file all Medicare, Private Insurance, Medicaid and supplemental health care claims in strict accordance with federal and state government guidelines. We are required to obtain your signature so that standard, required insurance forms may be completed properly. Please provide your signature in the space below. Your signature indicates that you have read the information detailed in this form. If you have any questions please discuss them with a member of the staff prior to signing this form.

SIGNATURE ON FILE

- I authorize use of this form on all my insurance submissions.
- I authorize release of information to my Insurance Carrier.
- I understand that I am responsible for my bill.
- I authorize payment to my doctor.
- A copy of this authorization may be used in place of the original.

_____ _____

Patient Signature Printed Patient's Name

REFRACTION POLICY

Refraction is the process of determining the eye's refractive error for medical diagnostic purposes or the need for corrective lenses. It is an essential part of an eye examination, but it is NOT a covered service by Medicare or most private insurances. Our office fee for the refraction is $25 and this fee is collected in addition to the patient's co-pay.

ACKNOWLEDGMENT

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service. The co-pay is separate from and not included in the refraction fee.

_____ _____

Patient Signature Date