REFRACTION FEES AND CO-PAYMENTS

A **refraction** is an important part of an eye examination. It is the test performed which determines your prescription. It also helps us monitor the health of your eye by determining your best possible visual acuity. This aids us in monitoring cataracts, macular degeneration and other disease and aging processes in your eye. Unfortunately, **Medicare** and other **medical insurances** such as **BlueCross and BlueShield do not pay** for this service. Medical plans deem refractions as "vision services" and therefore, do not cover or pay for the refraction. Our fee for refraction is $40.00 and is collected at the time of service in addition to any co-payments your plan may require. A refraction is performed at comprehensive annual exams, final cataract post-op visits when glasses are prescribed, when a change in visual acuity has occurred, or at your request.

Vision insurances, such as VSP and VCP, **do cover** the refraction. There may be times that an additional medical test is performed on the same day as a routine eye exam, such as fundus photography. Vision insurance plans do not cover for medical tests. This portion will be filed with your medical plan. When this occurs there is a co-payment that your medical insurance requires us to collect. It will be collected on the day of service in addition to co-payments required by your vision plan.

It is our intention to provide you with quality vision and ocular health exams. It must be said that not all services that are necessary for quality care are covered by every insurance plan. We strive to be certain that you receive the full benefit of your insurance plans. Please let us know ahead of your examination as to **all your current insurance benefits.** If for any reason we are paid by a medical plan for a refraction, or a co-payment was not required, we will reimburse you accordingly once we are notified. We thank you for choosing us for your eye care services.

PATIENT ACKNOWLEDGEMENT

I have read the above information and understand that a refraction is a non-covered service by medical plans. I also understand that a co-payment maybe required from both my vision plan and medical insurance if both must be billed for separate services performed on the same day. I accept full financial responsibility for refraction fees, co-payments, co-insurance and/or deductibles and understand it is due at the time of service.

Signature _____ Date _____

Printed Name: _____

I decline (please circle) the refraction or additional medical test today. I understand that without the advised testing , the doctor may not be able to fully assess the health and function of my eyes.

Signature_____ Date _____

Printed Name _____