Refraction Consent

The REFRACTION is an important part of your eye exam. It is used to establish the focusing error of each eye and provide the necessary information for writing an eyeglass prescription and it serves as a starting point for determining your contact lens prescription. Although the REFRACTION is done to aid the doctor in your best possible visual acuity and determine your visual progress, it is considered by many medical insurances carriers to be "routine" and therefore is a **non-covered service.**

A refraction may be necessary to help the doctor answer questions such as **"How much has my vision changed since my last visit?", "Can my vision be improved?",** etc.. You may decline with the understanding that a current glasses or contact prescription **cannot be generated without this information, and any visual change cannot be thoroughly assessed without it. A refraction is not just to obtain a glasses prescription.**

☐ I **AGREE** to have a REFRACTION (if necessary), and will pay the **$65** charge if not covered by my insurance.

☐ I am **DECLINING** a Refraction today.

_____ _____

Patient Signature Date

Non-Covered Diagnostic Testing Policy

Your doctor may want to do additional diagnostic testing on you for various medical reasons, and **depending on your diagnosis and insurance plan, these tests may or may not be covered.**

This testing will be coded and billed by your doctor as they seem fit. It is important to know that the coding of this visit **will not be altered once performed.** Meaning, that if a test is performed and your insurance carrier does not deem this test medically necessary, or the diagnosis code used is not a covered diagnosis, the doctor and biller will **not** change your coding or diagnosis code. If your insurance carrier does not pay for your testing and deem it a non-covered service or not medically necessary, then you are held liable for the unpaid services

So you may be aware of the possible charges incurred, the fee schedule is as follows:

OCT Scan $100 Visual Field $150 Fundus Photo $130 Tear Lab $50 Pachymetry $40 Topography $60

Not all services that you may receive are listed above. By signing below you acknowledge that you have been made aware of our Non-Covered Service Policy and agree to pay in full the balance for **any** unpaid service by your insurance provider. Payments are due within 30 days of invoice, otherwise late fees can occur.

_____ _____

Patient Signature Date