Patient Name: _____ D.O.B.: _____

Refractions

A refraction is a test to determine how well you can see. It involves showing you a series of lenses ("Better one? Or two?"), and results in a new and/or updated glasses prescription. If we find that your sight cannot be improved with glasses, this could be important information to help us determine if you have some sort of eye disease. This test is covered by most vision plans, such as Vision Service Plan (VSP), but is not covered by most medical insurances. The cost of the refraction is **$65.00** which is due at the time of your visit. ***If you are a contact lenses wearer, the refraction is necessary in order to renew your prescription.***

☐ **Yes** I do wish to have a refraction ☐ No I do not wish to have a refraction

_____ _____

Signature of patient, or parent/legal guardian Date

Coordination of Benefits

For patients who have both vision insurance (such as VSP) and medical insurance, we may bill one or both plans. We will bill only the vision plan for routine vision exams where the patient has no complaints or just needs new glasses or contact lenses. The vision plan does NOT cover evaluation or treatment of non-routine eye conditions such as cataracts, glaucoma, infections or other health-related complications. If you have a pre-existing medical condition or you are diagnosed with any during your visit, your medical insurance will also be billed. You are responsible for any copayments or deductibles your insurance mandates.

I have read the above and understand that both my vision plan and my medical insurance may be billed.

_____ _____

Signature of patient, or parent/legal guardian Date

Our Financial Policy

As a courtesy, we will gladly bill your insurance for your visit. To do so, all current insurance information must be provided before services are rendered, or you will be responsible for the entire balance. It is essential that you understand your insurance plan and how it is administered. We will not mediate any disputes between you and your insurance. You are fully accountable for charges that result if your claims are denied for non-covered benefits, failure to get proper referrals, expired referrals, or lapsed benefits.

We reserve the right to charge for appointments missed or cancelled without advance notice of at least two full business days. _____ (Initial) **Please note a no-show/same day cancellation fee will be imposed.**

I certify that all the information given is true and correct. I authorize the release of any medical information necessary to my health plan. As stated in the Financial Policy, I accept full responsibility for all charges related to my medical treatment.

_____ _____

Signature of patient, or parent/legal guardian Date

Revised May 2019