

# NOTIFICATION OF SERVICES NOT COVERED BY MEDICAL INSURANCE

## REFRACTION SERVICE AND FEE FOR GLASSES AND CONTACT LENS

A refraction is the process of determining if there is a need for corrective eyeglasses or contact lenses. It is an essential part of an eye examination and necessary to write a prescription.

**Most medical insurance plans, including Medicare, do NOT cover routine refractions.** Medicare allows that we charge separately for that portion of the examination, since it is not a covered service.

If you have a separate **vision plan** that covers routine or annual eye examinations and/or glasses, please let us know. Your vision plan may assist you with your eye care needs that are not covered by your medical plan.

**Our office fee for refraction is \$65** and this fee may be collected at the time of service in addition to any co-payment your plan may require. Should your plan pay us for the refraction, we will reimburse you accordingly.

## CONTACT LENS EVALUATION

All contact lens wearers require a contact lens evaluation every year. In doing so, the doctor assesses your eyes to make sure your contact lenses fit properly and that your vision with contacts is stable.

If you are an existing contact lens wearer, the doctor must evaluate the current lenses you are in and make sure they are still satisfactory in fit and vision.

The cornea, lids, and lashes are also specifically checked for diseases and abnormalities that would make contact lens use unsafe.

**Most medical insurance plans do NOT cover contact lens evaluation; our office fee for this service is \$50.**

## Patient Acknowledgement

I have read the above information and understand that the refraction and contact lens evaluation are non-covered services. I accept full financial responsibility for the cost of these services and understand it is due at time of service. I understand that any co-payment, coinsurance, or deductibles I may have are separate from and not included in the refraction and contact lens evaluation fees.

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Patient Signature (Parent for Minor)

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Date

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Print Name of Patient

