

Associate Ophthalmologist, P.C
REFRACTION WAIVER

1. WHAT IS REFRACTION?

Refraction is the process of determining the eye's refractive error, or need for corrective glasses and/or contact lenses.

2. WHY IS IT SOMETIMES NECESSARY?

Refraction is sometimes necessary depending on the patient's diagnosis and/or complaints presented that day. For example, if a patient is experiencing blurred vision or a decrease in visual acuity on the eye chart, a refraction would be needed to determine if this is due to a need for glasses or a medical problem. Refraction is also necessary to demonstrate to your insurance the need for cataract surgery or other medical procedures. We must prove that your vision cannot be simply improved with a glasses prescription. As you can see, refraction is an essential part of an eye exam; however, Medicare and most insurance providers DO NOT cover it.

3. MAY I DECLINE THE REFRACTION?

If you decline, we will not be able to determine the cause of any change in vision. We may not be able to prescribe contact lenses or glasses without a refraction.

4. HOW MUCH IS THE REFRACTION?

Our office policy is to charge **\$50** for this procedure in addition to the office visit co-pay and/or deductible. This is due at the time services are rendered. We will bill your insurance according to the contracted fee schedules. ***If your insurance pays the fee, we will gladly reimburse you the \$50.***

***NOTE:** This fee is due and payable whether or not you receive a written prescription for glasses or contact lenses or both. Sometimes the change is not significant enough to warrant the cost of purchasing new glasses and a new prescription will not be given. The fee covers the technician's and/or physician's time and effort in administering the refraction.*

ACKNOWLEDGEMENT

I have read the above information and understand the refraction may be a non-covered service. I accept full financial responsibility for the cost of this service. The co-pay and deductible are separate from the refraction fee.

Patient Signature (parent/guardian for minor)

Date

Vision vs Medical

Patient Name: _____ Date of birth _____

VISION EYE EXAM (Routine Visit):

This examination assesses whether vision can be improved with glasses or contact lenses and includes basic screening for eye diseases. ***I understand you bill for routine vision exam:***

Patient Signature (parent/guardian for minor)

Date

MEDICAL EYE EXAM:

This examination is for the diagnosis and treatment of eye diseases. If glasses or contact lenses do not improve vision, it may indicate an underlying medical eye condition. ***I understand you bill my medical insurance:***

Patient Signature (parent/guardian for minor)

Date

Refraction:

Refraction is the optical determination of the best possible vision. It is necessary to evaluate whether any medical, optical, or surgical treatments may be needed. It is covered by vision insurance but is not typically covered by most medical insurance plans.

Do you want an eyeglass and/or contact lens prescription today? (circle) **YES NO**
If you answered YES, you need a refraction. Our office fee for the refraction is **\$50**, collected at the time of service, and is in addition to any co-payment.
Routine vision exams may sometimes cover this fee.

ACKNOWLEDGEMENT

I have read the above information and understand the refraction may be a non-covered service. I accept full financial responsibility for the cost of this service. The co-pay and deductible are separate from the refraction fee.

Patient Signature (parent/guardian for minor)

Date