NORTHEAST OHIO
EYE SURGEONS

Welcome to Northeast Ohio Eye Surgeons and thank you for allowing us to care for you. Please know we are committed to providing you with the best possible **vision and medical/surgical eye care**.

In preparation for your appointment, please review the enclosed patient education information and kindly note the following:

1. If your insurance requires a referral, please contact your Primary Care Physician to obtain this. They may fax the referral to the appropriate number listed below before the date of your appointment.
2. We suggest you verify your benefits with your insurance company before coming to our office. Our doctors have surgical privileges at Saint Clare's Surgery Center. Please ask your insurance company if this facility is in network prior to you scheduling surgery.
3. Please complete and sign the enclosed forms and bring them with you to your appointment.
4. Please bring both your medical and vision insurance cards. If your vision insurance does not provide you with a card, please bring the subscriber's name and Social Security Number with you, which will allow us to bill that insurance.
5. If your insurance requires a copayment, please bring this with you as it is due on the day of service. Copays not collected on the day of service with be assessed a $20.00 processing fee.
6. If you do not have insurance, a minimum deposit of $75.00 is due on the day of service.

Please allow at least three (3) hours for this appointment. This appointment allows us to complete important pre-surgical eye testing. Additionally, this appointment provides time for you to learn about and discuss surgical options with your surgeon and surgical counselor. Because of these discussions it is helpful to bring a family member with you. It is also important to have someone with you because your eyes will be dilated during this appointment. The dilation will cause your eyes to be temporarily light sensitive so we recommend you have someone drive you home from your appointment. **Please note: you will not be having surgery at this first appointment.**

If you have any questions, we welcome you to contact our office at one of the numbers below. We look forward to seeing you soon and thank you again for choosing Northeast Ohio Eye Surgeons.

Kent Office
2013 State Route 59
Kent, OH 44240
Office 330.678.0201

Stow Office
4277 Allen Rd.
Stow, OH 44224
Office 330.928.0201

Akron Office
4099 Embassy Pkwy
Akron, OH 44333
Office 330.836.8545

Patient Cataract Vision Questionnaire

Patient Name:_____ DOB: _____

The term "cataract" refers to the clouding of the eye's natural lens. When a cataract is removed, an artificial lens is placed in the eye to focus the vision. Patients having standard cataract implants/lenses will need glasses to see at different distances. New advances in cataract lenses have made it possible to reduce this need for glasses and potentially eliminate them altogether. It is important you understand that many patients still need to use glasses for some activities after surgery. This questionnaire will assist us in providing the treatment best suited for you if it is determined that you are a candidate for surgery.

1. Would you like to see without glasses at distance? ☐Yes ☐No

2. Would you like to see without glasses at near? ☐Yes ☐No

3. Circle the two (2) groups below that you would most prefer to see without glasses.

Group 1 (12-20 inches)	Group 2 (2-4 feet)	Group 3 (20 feet & beyond)
Newsprint	Computer	Driving
Phonebook	Headlines	TV
Maps	Menus	Sports
Sewing	Price tags	Movies

4. If you had to wear glasses after surgery for one (1) activity, for which activity would you be most willing to use glasses? ☐ Reading fine print ☐ Computer work ☐ Driving

5. What kind of work do you do? _____

6. What are your favorite hobbies? _____

7. How often do you drive in the dark? ☐ Never ☐ Seldom ☐ Often

8. Would you accept some halos around lights at night to be able to see better up close without glasses?
   ☐ Yes ☐ No

9. Please rate your personality by putting an "X" on this line.
   Easy Going ---------- | ---------- Perfectionist

10. Signature:_____ Date:_____

Patient Information Sheet

Name _____ Birthdate ___ / ___ / ___ Sex _____SSNo. _____

Last First

Address _____

Street City State, Zip

Home Phone _____Day Phone_____ Email Address:_____

Marital Status _____ Primary Care Doctor _____ Optometrist_____

Pharmacy of Choice _____City/Street _____

Responsible Party Information (required if patient is less than 18)

Name _____ Birthdate ___ / ___ / ___ Sex _____ SSNo. _____

Last First

Address _____

Street City State, Zip

Home Phone _____Day Phone_____ Email Address:_____

Relationship to Patient _____ Martial Status _____

Other Responsible Party _____ Home / Cell Number _____

Insurance Information

Primary Insurance:_____Policy Number _____

Name of Subscriber_____Subscriber's Date of Birth_____

Relationship to Patient_____ Copay Amt _____

Secondary Insurance:_____Policy Number _____

Name of Subscriber _____Subscriber's Date of Birth_____

Relationship to Patient_____ Copay Amt _____

Release of Information

If any family or friends should call our office about your healthcare or appointments we can not disclose any information unless you've listed them below. Please list the person(s) whom you give Northeast Ohio Eye Surgeons permission to discuss your medical care.

Name_____Phone_____

Name_____Phone_____ _____

Emergency Contact Name _____ Phone_____

Name: Date:

Occupation:

Birthdate:

Family Physician:

Systemic or General Health History Form

Please review the following complete lists and indicate conditions or surgeries that apply

General Medical History:

☐ **NONE of the Following Conditions**

ENDROCRINE:
- ☐ Diabetes**
  - ☐ Year Diagnosed:_____
  - ☐ Diet Controlled
  - ☐ Pills (No Insulin)
  - ☐ Insulin
- ☐ Thyroid Disease**
- ☐ Liver Disease
- ☐ Pituitary Problem**

CARDIOVASCULAR:
- ☐ A-Fib
- ☐ Arrhythmias (Irregular beat)
- ☐ Carotid (Neck) Artery blockage
- ☐ Heart Attack (MI)
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Bleeding / Clotting Disorder
- ☐ Stroke**
- ☐ TIA (mini-stroke)
- ☐ _____

NEUROLOGICAL:
- ☐ Bell's Palsy**
- ☐ Epilepsy
- ☐ Headaches/Migraines
- ☐ "Ocular Migraines" **
- ☐ Multiple Sclerosis**
- ☐ Parkinson's Disease**
- ☐ _____

EAR-NOSE-THROAT:
- ☐ Acoustic Neuroma**
- ☐ Allergies - Seasonal
- ☐ Dizziness or Vertigo
- ☐ Hearing Impaired
- ☐ Meniere's Disease**
- ☐ _____

PULMONARY- LUNG:
- ☐ Asthma
- ☐ Breathing problems
- ☐ Emphysema / COPD
- ☐ Sarcoidosis**
- ☐ Sleep Apnea
- ☐ _____

General Medical History Cont'd:

AUTOIMMUNE - SKIN - MUSCULAR:
- ☐ Acne Rosacea**
- ☐ Arthritis - General (Osteo)
- ☐ Connective Tissue Disorder
- ☐ Dermatitis/Eczema/Psoriasis
- ☐ Fibromyalgia
- ☐ HLA-B27 + **
- ☐ Lupus (SLE)**
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis**
- ☐ Scleroderma**
- ☐ Sjogren's Syndrome**
- ☐ _____

RENAL-URINARY-REPRODUCTIVE:
- ☐ Dialysis
- ☐ Renal Failure**
- ☐ Pregnant or Nursing
- ☐ _____

DIGESTIVE:
- ☐ Crohn's Disease**
- ☐ Irritable Bowel Disease
- ☐ Ulcerative Colitis**
- ☐ _____

COGNITIVE - EMOTIONAL:
- ☐ Anxiety
- ☐ Bipolar
- ☐ Depression
- ☐ Developmentally Delayed
- ☐ Learning Disorder (please specify)
  - ☐ Mild _____
  - ☐ Mod/Severe _____
- ☐ Psychiatric Disorder _____
- ☐ _____

CANCER: (Please specify type)
- ☐ Basal Cell Carcinoma
- ☐ _____

List any other important health issues:

_____

_____

_____

_____

_____

Infectious Conditions:

☐ **NONE of the Following Conditions**
- ☐ AIDS/HIV + **
- ☐ Cold Sores
- ☐ Histoplasmosis**
- ☐ Hepatitis; Type _____
- ☐ Meningitis
- ☐ Sexually Transmitted Disease (please specify) _____
- ☐ Toxoplasmosis**
- ☐ Tuberculosis**
- ☐ _____

Non-Eye Surgeries:

☐ **NONE of the Following Surgeries**
- ☐ Amputation _____
- ☐ Back Surgery
- ☐ Bladder Surgery
- ☐ Brain Surgery**
- ☐ Colon Surgery
- ☐ Gallbladder Surgery
- ☐ Gastric Bypass
- ☐ Heart Surgery (please specify)

_____
- ☐ Hip replacement
- ☐ Hysterectomy
- ☐ Knee Surgery
- ☐ Mastectomy
- ☐ Organ Transplant (please specify)

_____
- ☐ Pituitary Surgery**
- ☐ Thyroidectomy

List any other major surgeries:

_____

_____

_____

_____

_____

_____

_____

_____

Name: Date: Birthdate:

Ocular (Eye) History Form

Please review the following complete lists and indicate conditions or surgeries that apply

Past Eye History:

☐ **NONE of the Following Conditions**

☐ Amblyopia—Lazy Eye
- ☐ Patched as a Child
- ☐ Not Patched

☐ Cataract

☐ Cataract Surgery
- ☐ Right Eye:
  - Date: _____
  - Surgeon: _____
- ☐ Left Eye:
  - Date: _____
  - Surgeon: _____

☐ Corneal Dystrophy
- ☐ Fuch's

☐ Double Vision

☐ Dry Eye Syndrome

☐ Glaucoma

☐ Glaucoma Suspect

☐ Glaucoma Laser/Surgery
- ☐ Right Eye Date _____
- ☐ Left Eye Date _____

☐ Herpes Simplex in eye

☐ Histoplasmosis in eye

☐ Iritis

☐ Keratoconus

☐ LASIK/PRK/Refractive Surgery
- ☐ Right Eye:
  - Date: _____
  - Surgeon: _____
- ☐ Left Eye:
  - Date: _____
  - Surgeon: _____

☐ Macular Degeneration
- ☐ Dry Form
- ☐ Wet Form

☐ Nystagmus

☐ Ocular Vein Occlusion

☐ Optic Atrophy (Optic Nerve Damage)

☐ Optic Neuritis

☐ Orbital Fracture

☐ Pseudotumor Cerebri —Intracranial Hypertension

☐ Pterygium

☐ Retinal Detachment
- ☐ Laser Treatment
- ☐ Buckle Procedure

☐ Retinal Tear with Laser

☐ _____

History of Head or Eye Trauma:

☐ **No Significant Traumas**

☐ Assault with Head trauma
☐ Blunt Trauma to eye
☐ Chemical Injury to eye
☐ Foreign Body in eye
☐ Motor Vehicle Accident
☐ Sharp Object to eye
☐ Sports Injury
☐ _____

Have you EVER taken the following medications?

☐ Flomax or Tamsulosin

Are you CURRENTLY taking any of the following medications?

☐ Aspirin ☐ Coumadin
☐ Plaquenil ☐ Plavix
☐ Prednisone ☐ Warfarin

Family Eye History

☐ **NONE of the Following Conditions**

(please specify the affected family member)

☐ Glaucoma _____
☐ Macular Degeneration _____
☐ Keratoconus _____
☐ Retinal Tear/Detach _____
☐ Blindness _____

Social History

Alcohol:
☐ Yes; how many/day _____
☐ No

Tobacco Use:
☐ Current every day smoker
☐ Current some days smoker
☐ Former smoker
☐ Never smoker
☐ Unknown if ever smoked
☐ Smokeless Tobacco

Recreational Drugs:
☐ Yes; what/how often _____
☐ No

Medications

☐ **Not currently on any Medications**

Please list all current medications or provide a list:

(Depending on where you get your prescriptions filled, we may be able to pull this information directly from your pharmacy)

_____
_____
_____
_____
_____
_____
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_____
_____
_____
_____

ALLERGIES

☐ **No Known Drug Allergies**

Please list any allergies to Medications with reaction:

_____
_____
_____
_____
_____
_____
_____
_____

NORTHEAST OHIO EYE SURGEONS

Signature on File and Assignment of Benefits

Patient Name (print) _____ Patient Date of Birth _____

1. **Medicare:** I request that payment of authorized Medicare, Medicaid, or other insurance benefits be made on my behalf to Northeast Ohio Eye Surgeons for any service furnished to me by a physician of the group. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents or other insurance information needed to determine these benefits payable for related services. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare contractor, and I am responsible for the Medicare deductible, co-insurance or the 20% Medicare does not pay, and for any non-covered services.

2. **Medigap:** I also request that the payment of authorized Medigap benefits or other secondary insurance be made either by me on my behalf to Northeast Ohio Eye Surgeons, or any physician of that group, for services provided to me by a physician of the group. I authorize any holder of medical information about me to release it to my Medigap insurer any information needed to determine these benefits payable for related services. I understand I am responsible for any deductible, co-pay, co-insurance and/or any non-covered procedures.

3. **Release of Information:** Northeast Ohio Eye Surgeons may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug use, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to Northeast Ohio Eye Surgeons for reimbursement for services rendered (2) any health care provider for continued patient care. Northeast Ohio Eye Surgeons may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection for statistical data or pursuant to State or Federal law, statute, or regulation. A copy of this authorization may be used in place of the original.

4. **Other Insurance:** I understand that Northeast Ohio Eye Surgeons maintains a list of health care service plans with which it contracts. A list of such plans is available for the business office and that Northeast Ohio Eye Surgeons has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Northeast Ohio Eye Surgeons if I belong to a plan that does not appear on the above mentioned list.

5. **Non-Covered Services:** I understand that Northeast Ohio Eye Surgeons contracts with health care service plans (i.e. HMO's, PPO's) relate only to items and services which are covered by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient and treatment or test not authorized by the health care service plan. The undersigned agrees to cooperate with Northeast Ohio Eye Surgeons to obtain necessary health care service plan authorizations.

Signature of Patient or Authorized Party _____ Date _____

NORTHEAST OHIO
EYE SURGEONS

Patient Financial Policy Statement

Welcome to Northeast Ohio Eye Surgeons and thank you for choosing us to be your eye care provider. Your clear understanding of our financial and practice policies is important to our relationship with you. We are committed to exceeding the expectations for quality eye care through qualified trained staff and doctors.

For your convenience: insurance claim forms will be prepared and sent to your insurance company(s) on your behalf for exams and procedures performed by the doctors at Northeast Ohio Eye Surgeons. A statement for your deductible, co-insurance and/or any non-covered charges will be sent to you as we receive an explanation of payment from your carrier. Balances are due upon receipt of the statement. Please be aware that the balance on your acccount is your responsibility whether or not your insurance company pays the claim. Accounts with unpaid balances may be forwarded to a collection agency. Personal checks that are returned for non-sufficient funds are subject to administrative fees.

Each office visit billed is based upon clinical information, not based on coverage by insurance companies. We follow our patients for vision and medical diagnosis, please be sure to let us know if you are here for an annual/biannual eye exam. To request a diagnosis change solely for the purpose of securing reimbursement from an insurance company is considered insurance fraud and will not be done by our office. All patients are required to complete our patient information form and health history questionnaire.

Co-pays are required at the time of service. We try our best to collect the correct co-pay amount from you at the time of service as required. To help with correct co-pay and insurance billing it is imporant that you keep the office up to date with your insurance information. If an office copayment is not paid at the time of your visit a service fee will be charged per practice policy.

Please be advised that the contract between you and your insurance company is a separate contract from the relationship between you and our practice. It is your responsibility to be knowledgeable of your insurance coverage/benefits/eligibility and to alert us should your insurance or copay change. If proof of coverage cannot be provided at each visit you will be responsible for payment in full at the time of service.

Workers Compensation or automobile accident claims will be billed directly to the carrier. Payment of any disputed or denied claims will be your responsibility. A service charge for filling out forms or FMLA papers may be charged per practice policy.

Medicare recipients and Medicare HMO recipients: Medicare and related Senior Health Plans do not cover routine vision testing and refractions. Refraction is the test that is done to see if vision can be improved with glasses. Refraction is an out of pocket expense with payment due at the time of service.

Appointment Utilization: We kindly request at least 24 hours notice when cancelling or rescheduling your appointment. Missed appointment times could be used to treat other patients in need of care. No Show/missed appointments may be charged a service charge per practice policy. Please help us provide the best care for you and our other patients by keeping your scheduled appointment. Additionally, to prevent delays in care please do not use a cellphone/text when a care provider is with you.

Patient Signature_____ Date:_____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

The purpose of this Notice is to provide you with information regarding our privacy practices, including the ways in which we may use or disclose your health information. The Notice also describes your rights and our obligations concerning such uses and disclosures.

Uses and Disclosures
Northeast Ohio Eye Surgeons is committed to maintain the privacy and confidentiality of your health information.

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, laboratory results, surgery information, specialized testing, co-management information, etc. will be available in your medical record to all health professionals who may provides treatment now or in the future.

Payment. Your health information may be used to seek payment from your health plan or other sources of payment, including finance companies that you may use for services. For example, your health plan may request dates of service, services rendered, and diagnosis.

Healthcare operations. Your health information may be used for evaluation of the day to day operations of Northeast Ohio Eye Surgeons. For example, your procedure or services may be used for financial reporting.

Family and Friends. With your approval and using our professional judgment, your health information may be disclosed to designated family, friends, and others who are directly involved in your care or the payment of your care. If you are unavailable, incapacitated, or in an emergency medical situation, and we determine that a limited disclosure may be in your best interest, we may share limited health information with such individuals without your approval.

Law enforcement. Your health information may be disclosed to law enforcement officials, without your permission, to support government audits and inspections and to comply with government reporting.

Public health reporting. Your health information may be disclosed to public health officials as required by law. For example, we are required to report certain infectious diseases to the state's public health department.

Worker's compensation. Your health information may be disclosed, for purposes of payment, if there is a work related illness or injury.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your written authorization. A written revocation of the authorization can be made at any time. This revocation will not affect the previous release of information.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to remind you of upcoming appointments.

Newsletters. Your health information will be used by our staff to send you a newsletter. You may call our office if you do not wish to receive the newsletter.

Your Rights

Restrictions on Use and Disclosure of Individual Health Information. You have the right to request restrictions on some of our uses and disclosures of your health information. These restrictions must be made in writing and signed by you. This office is not required to abide by your restrictions. We retain the right to terminate a restriction if we believe such termination is appropriate. You have the right to terminate, in writing or orally, any restriction by sending such termination notice to the Compliance/Privacy Officer at 2013 State Route 59, Kent, Ohio 44240.

Access to Individual Health Information. You have the right to inspect and copy your health information maintained by this office. All requests for access must be made in writing and signed by you or your representative. There may be a nominal fee per page and for postage, if a mailed copy is requested. You may obtain a request for access form from the Compliance/Privacy Officer at 2013 State Route 59 Kent, Ohio 44240.

Amendments to Individual Health Information. You have the right to request in writing that your health information maintained by this office be amended. In certain cases, we may deny your request for the amendment. All Amendment requests must be made in writing and signed by you or your representative and must state the reason for the amendment. You may obtain an amendment request form from the Compliance/Privacy officer at 2013 State Route 59, Kent, Ohio 44240. If we deny your request, you may submit a statement of disagreement to us. Please contact the Compliance/Privacy Officer for questions about amendments to your health information.

Accounting for Disclosures of Individual Health Information. You have the right to receive an accounting of certain disclosures made by us of your health information. Requests must be made in writing and signed by you or your representative. Accounting request forms are available from the Compliance/Privacy Officer at 2013 State Route 59, Kent, Ohio 44240. There may be a nominal fee for each accounting you request. The right to receive this information is subject to certain exceptions, restrictions, and limitations.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Compliance/Privacy Officer at 2013 State Route 59, Kent, Ohio 44240. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. in writing. There will be no retaliation for filing a complaint.

Additional Information

If you have any questions or need additional assistance regarding this Notice, you may contact the Compliance/ Privacy Officer at 2013 Ste Route 59, Kent, Ohio 44240 or by phone (330) 678-0201.

Patient Signature: _____ Date: _____

_____NEOES employee initial here to verify patient received a copy of this Notice.

2/03 kmk; updated 9/08 tlb

◯Routine Eye Exams, Medical Eye Exams, and Refractions

Please Read Before Your Eye Examination

Regular eye examinations are important to maintain your vision for your lifetime. It is important that you be aware of your insurance benefits and how they apply to your visit, so you will know how billing will be handled. Ultimately, it is your responsibility to know what your own medical or vision plan covers. We hope this information will help you to understand how your visit is submitted to your insurance for today's visit and future visits.

Benefits may vary based upon the reason for your visit. Your description of your eye condition will help us to determine whether your visit to the clinic is defined as "Routine" or "Medical". Your symptoms and eye examination will determine how your visit is coded and billed to your insurance.

Routine Eye Examinations A "routine eye exam" takes place when you come for an eye examination without any medical eye problem, and there are no symptoms except for visual changes that can be corrected by eyeglasses or contact lenses. The doctor screens the eyes for disease and finds no medical problems. Glasses and contact lens prescriptions may be updated.

Medical Eye Examinations Your visit will be coded as a "medical eye examination" whenever you are being evaluated or treated for a medical condition or symptom that you bring up, eye problems you tell our staff about, or a condition that the doctor finds during the examination. Examples that will necessitate your visit being submitted to your medical insurance include headache, diabetes mellitus, eye irritation, dry eyes, allergies, floaters, contact lens intolerance, glaucoma, cataract, eye muscle imbalance, "lazy eye", macular degeneration, and visual changes not corrected by glasses or contact lenses. Please note that if you have diabetes mellitus, and would like us to send a letter to your primary care physician regarding your eye examination, the visit will be coded as a "medical eye examination".

Vision Plans If you have a vision plan, i.e. Vision Service Plan (VSP), EyeMed, etc., we need to be aware of this coverage prior to your exam. Vision plans cover only routine eye examinations. If you report symptoms during your visit related to an eye problem, disease, or injury, or your doctor determines that your problem falls under the category of a "medical eye examination", your visit will be billed to your medical insurance as primary. We then can submit and coordinate any services not covered by your medical plan (copays, refraction fee, etc.) to your vision plan as secondary.

If you determine that you have coverage through a Vision Plan **after** your exam has been completed, we will not bill the Vision Plan for you, but will be happy to provide you with a financial printout so you may file a claim with the Vision Plan.

In summary, how your eye exam will be submitted to your insurance carrier will depend not only upon what you tell the doctor, but also what the doctor finds upon examination. Insurance companies frown upon our changing the way we code your examination after the fact. Remember, there are vision plans that do not cover medical exams and medical plans that do not cover routine eye care. If you have any questions, please ask a member of our staff.

Please check one: ◯ I do NOT have Vision Plan ◯ I do have a vision plan _____ Initials

What is a Refraction?

Refraction is a vision test that determines your best-corrected vision with eyeglasses or contact lenses. This is a measurement that the doctor or technician takes with an instrument called a phoropter that holds corrective lenses in front of your eyes. While you look at the eye chart through the phoropter, the lenses are adjusted until the clearest vision is achieved. You may hear the doctor or the technician say something like, "which is better, lens one or lens two," for example.

This test is performed on your first visit with us, your annual visit, and anytime your vision drops significantly. The refraction is a vital test to the care of your eyes because it allows for assessment of your current eye health and the detection of eye diseases. With it, we may provide you with a prescription for updated glasses or it may be required by Medicare, or other insurance plans to determine if you qualify for particular eye procedures such as cataract or laser eye surgeries. If you had eye surgery, this test is performed to determine your best vision and is included in your post-operative care for up to 90 days.

Will your insurance pay for a refraction?

Even though this is a vital test to the care of your eyes, the refraction is a non-covered service through Medicare, and most insurance plans. Unfortunately, they do not differentiate between "medical refractions" and refractions performed solely for the purpose of providing glasses/contact lenses. We are required to charge for this service regardless of whether insurance will pay.

There is a fee of $49.00 for this test that you will be asked to pay at the time of your visit. If you have a secondary vision plan, we can submit this charge to them for consideration. This a routine charge at all Medical and Surgical eye care offices. If you wish to forego the refraction, please inform us BEFORE we begin doing any testing of your eyes. However, sometimes a refraction may be required to determine the health of your eyes. Foregoing your refraction may limit your doctor's ability to accurately diagnose and treat serious medical conditions.

I understand the difference between routine and medical eye examinations and the potential implications of these differences on which type of insurance gets billed and the potential for fees that may include co-pays, deductibles, and/or co-insurance fees. I understand that I am responsible for any of these fees that my insurance does not cover. I further understand that a refraction is an important test that I may need, and if so, that I will be responsible to pay for this test.

Patient Name: _____

Patient Signature:_____ Date_____