Wolstan& Goldberg Eye Associates

REFRACTION POLICY AND CONTACT LENS POLICY

An important part of an eye exam is the REFRACTION. A Refraction is the vision exam that determines the need for a refractive correction such as glasses and/or contact lenses. This is considered a VISION benefit vs. MEDICAL exam. Therefore most insurance, including Medicare, **DO NOT** cover this test. If you have a separate Vision plan please alert the staff and make a decision whether your exam will be billed to your Medical insurance **OR** Vision plan. Even if there is no change in your prescription, you are still responsible for the fee as the test was performed. Our charge for this test is $50.00 and payable at the time of service. A contact lens prescription is also a separate exam with additional fee's that may vary depending on the patient's history of contact lens wear.
Some HMO insurance will cover a portion of the Refraction but have a **separate copayment** for the vision exam. If you have other concerns regarding our policy please feel free to speak with our staff. If for some reason you find your Refraction to be unsatisfactory we will honor a prescription recheck within the first 60 days from the original date prescribed. This happens due to unpredictable changes in the vision. If a new Refraction is needed there will be a $50.00 charge due at the time of service.

ACKNOWLEDGMENTS

I have read all the information and understand that the Refraction and Contact Lens exam is not covered by Medicare and most other health insurances. The insurance copay is a separate charge and is not included in the refraction fee. I accept full financial responsibility for the refraction fee, copay, and any other service that is not covered by my insurance or if I am a cash paying patient. I also agree that payment is due at the time services are rendered.

Although I may choose to decline a Refraction, by signing this document I acknowledge and understand Wolstan& Goldberg Eye Associates' Refraction Policy.
I understand there will be a $25.00 return check fee for all returned checks.

ASSIGNMENT OF BENEFITS

I hereby authorize payment of my medical, surgical and vision benefits to Wolstan& Goldberg Eye Associates. I authorize this office to release any information required to process all claims for reimbursement on my behalf. The above providers participate with Medicare and other insurances; therefore I understand that the patient is responsible for applicable deductibles, co-insurance, co-payments and non-covered services. I understand I am financially responsible for any charges incurred if my insurance is not in effect on the date of services. A copy of this authorization may be used in place of the original.

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Signature   Date

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Print Name

Name of patient if different from above:_________________________

If not signed by the patient, please indicate relationship:
❑ Parent of minor   ❑ Guardian of minor   ❑ Conservator of patient