AVERY EYE CLINIC

YOUR VISION IS OUR FOCUS

Board-Certified Medical and Surgical Ophthalmologists
Fellows of the American Academy of Ophthalmology

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Refraction Advance Notification

Date:_____ Patient's Name:_____

INS/MCR/MCD ID #:_____ MD:_____

The refraction test is an eye examination that measures a person's ability to see an object at a specific distance. The doctors at Avery Eye Clinic can determine if you have nearsightedness, farsightedness, astigmatism (asymmetrical cornea), or presbyopia (inability to focus on objects that are close to you). This test helps confirm the extent of vision difficulty. The information obtained from a refraction test is used to determine if a patient has normal vision. When a person complains of blurred vision, this test can help determine the extent of poor vision. It can also be performed to help follow the progress of treatments for diseases of the eye such as cataracts. The test is also used to allow the prescription for eyeglasses or contact lenses to be correct for each person, if needed.

Medicare, Medicaid, and most commercial insurance plans **do not cover refractions**. If your ophthalmologist determines that you need to have a refraction performed and your insurance is one that does not cover it, you will be held responsible for paying that portion of the exam fee, along with any other fees you are normally responsible for (i.e. copayments/deductibles) at the time of service. Medicare and Medicaid only reimburse for services that they deem medically necessary or are benefits of special preventive and screening programs.

Specific Service(s):

Refraction (CPT 92015) is a non-covered benefit as it is considered "routine" in nature. The fee for this test, when necessary, is $40.00.

"I understand that, in the opinion of my ophthalmologist, the service listed above and provided to me may not be covered under my commercial insurance, Medicare, or Medicaid as reasonable and necessary for my care. I understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be a covered benefit."

_____ _____

Date *Signature of patient or person acting on patient's*

_____ _____

behalf Date *Signature of Witness*

Date of Service:_____ Patient:_____ Witness: _____

Date of Service:_____ Patient:_____ Witness: _____

Date of Service:_____ Patient:_____ Witness: _____

Date of Service:_____ Patient:_____ Witness: _____