

**Patient Acknowledgement Regarding
Precautions Following Dilation**

It may be necessary to dilate your eyes during the course of your eye examination or treatment. Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye. Dilating drops may diminish your vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your doctor to predict how much your vision will be affected.

Refraction Service and Fee

Refraction is the process of determining your best corrected vision and if there is a need for corrective eyeglasses or contact lenses. It is an essential part of an eye examination and is necessary to write a prescription for glasses or contact lenses. It can also help track the progress of treatments or diseases of the eye.

Refraction is NOT a covered service by **Medicare** or most insurance plans. Many plans do not differentiate between “medical” refraction and refraction performed solely for the purpose of providing glasses.

We will submit this charge to your insurance carrier on your behalf whether or not they cover the charge.

The fee for refraction is \$60.00 and this fee is collected at the time of service in addition to any copayment, deductible, or coinsurance your plan may require. Should your insurance plan pay us for refraction, we will reimburse you accordingly.

Contact Lens Evaluation

A contact lens wearer should wear contacts to the eye exam. Evaluation of the fit and power will be part of that exam. If change is needed, then a separate appointment will be scheduled. Costs for refits and contact lenses are variable. Our office will check with your insurance carrier if you have a contact lens benefit for eligibility and allowance.

I have read and understand the above information. I accept full financial responsibility for the cost of a refraction and/or a contact lens evaluation, if provided, and understand payment is due at time of service. I understand that any copayment, coinsurance or deductible I may have is separate from and not included in either the refraction fee or contact lens evaluation fee.

Patient's Name (Printed)

Date

Relationship to Patient

**Patient's Signature or
Legally Responsible Adult for minor**

Staff Witness