Parkway
FAMILY EYE CLINIC

Medicare Refraction Policy

Notice of Exclusion from Medicare Benefits in 2015

A refraction is the process of determining if there is a need for corrective lenses to see clearly. This series of tests determines the eye glass or contact lens prescription.

Most medical insurance plans, including Medicare, do NOT cover routine refractions or routine eye examinations (when no medical eye problem is known or suspected). Medicare requires that we charge separately for that portion of the examination, since it is not a covered service. At times, it is medically necessary to perform a refraction to help determine the cause of visual changes. This is particularly helpful when patients have multiple issues affecting their eyes such as cataracts, glaucoma, and macular degeneration. Despite being medically necessary, refractions are still not considered a covered service.

If you have a separate vision plan that covers routine or annual eye examinations and/or glasses, please let us know. Your vision plan may assist you with your eye care needs that are not covered by your medical plan. The refraction fee is a separate fee from the eye examination fee and is due at the time of service, along with any copay or co-insurance required by your insurance plan.

Our office fee for a refraction is $35^{00}. Should your plan pay us for the refraction, we will reimburse you accordingly.

Benefit Assignment/ Release of Information

I hereby assign all medical and/or routine benefits to include medical, optical materials, and routine vision benefits to which I am entitled, including Medicare and private insurance and third party payers to **Douglas A. Anania, O.D., D.B.A. Parkway Family Eye Clinic, Inc**. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize the release of all information, including Medical Records to the Health Care Financing Administration or Insurance Company, as needed, to determine the level of benefits as necessary, to secure payment for related services.

Financial Policy Statement

It is our policy, that all payments are to be made at the time of the office visit, unless it is determined that your insurance policy includes specific vision benefits accepted by this office. Insurance carriers are billed solely as a courtesy to you. If your insurance carrier does not remit payment within **60 days** from the time of billing, the balance will be due in full from you. If any insurance or third party payment is paid directly to you for services billed by our office, you are responsible for prompt payment to our office. In the event that you are billed for services, invoices that go unpaid for **90 days** will be turned over to a third party and/or collection agency. Fees for services associated with any office visit are non-refundable. I understand and agree that if I fail to make any of the payments for which I am responsible, in a timely manner, I will be responsible for all costs of collecting payments owed; this can include court costs, collection agency fees, and attorney fees. Fees for services associated with any office visit are non-refundable.

I have read the information presented above and understand my responsibility for the payment of my account.

Patient Name: _____ Medicare#_____

_____ _____

Date Signature of Patient or Legal Representative