REFRACTION SERVICE AND FEE

A refraction is the process of determining the degree of refractive error in a patient's eyes. Common refractive errors include Myopia (nearsightedness), Hyperopia (farsightedness), and Astigmatism. The combination of these different types of refractive errors makes up a glasses or contact lens prescription.

A refraction may need to be performed as part of a preoperative evaluation for surgery. It may also be performed to help diagnose diseases of the eye. Most commonly, a refraction is done so that patients can have a prescription to purchase glasses or contact lenses.

Refractions are considered a NON-COVERED SERVICE by Medicare, as well as most other insurance plans that do not offer coverage for Routine Eye Examinations. Because this service is not covered, Medicare requires that we charge for this service separately when performed. If you have Medicare, or another insurance plan that does not cover Routine Eye Examinations, you will be charged separately for the refraction

If you have separate Vision Insurance (VSP) that does provide coverage for Routine Eye Examinations, please let us know. Your Vision Insurance may provide coverage for refractions as supplemental coverage of eye care services not covered by your medical insurance

Our fee for a refraction is $70. This fee will be collected at the time of service, when the insurance information you provide indicates that the refraction is a Non-Covered Service for your plan. This fee is in addition to any co-payment required by your medication insurance. In the event that your insurance plan does provide coverage for the refraction service and a payment is collected from you in advance, we will reimburse you accordingly, once we verify payment from your insurance company.

If you have any questions regarding whether your insurance will cover the Refraction Fee or any other questions about insurance coverage in general, please do not hesitate to ask. We will do our best to assist you.

Patient Acknowledgement

I have read the above information and understand that the refraction is a NON-COVERED SERVICE by my insurance company. I accept full financial responsibility for the cost of this service and understand it is due at time the service is performed. I understand that any co-payment, coinsurance, or deductible I may have is separate from and not included in the refraction fee.

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Name of Patient or Personal Representative (Print) Date

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Signature of Patient or Personal Representative

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