

Refraction Policy

One of the most important parts of your eye exam today is the refraction service. This is the test that we perform with you looking at an eye chart through multiple sets of lenses until we find the glasses or contact prescription that allows you to see optimally. Refraction also provides us with important information about the function of your eyes and may alert us to any problems that are related to a decrease in visual acuity.

Unfortunately *medical* insurances do **NOT** cover this service as they have determined that it is not "medically" necessary. However, if you have *vision* insurance that covers this service (such as; **Tricare Prime, Medical Eye Services, Vision Service Plan Signature, Vision Service Plan Choice**) then refraction **IS** a covered service. Please check with your insurance carrier or Human Resources department for eligibility and benefits information.

Our fee for refraction is \$50.00, and unless you have vision insurance that covers the refraction charge, this fee is due at the time of service in addition to any co-payment your plan requires.

Please initial and sign below:

____ **I do NOT have vision insurance**, but **I consent** to receive the refraction service. I understand that refraction is a non-covered service. I accept full financial responsibility for the cost.

____ **I do NOT have vision insurance**, and **I decline** to receive the refraction service. I understand that the doctor may not be able to fully assess the health and function of my eyes.

____ **I DO have vision insurance**, and I consent to receive the refraction service. I have verified that my plan covers this service, but I accept full financial responsibility for the cost if my insurance denies payment.

Print Name

Signature

Date