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One of the most important parts of your eye exam today is the refraction. This is the part of the exam that will determine whether you can be helped in any way by new glasses or contact lenses. It is also how we determine the best possible visual acuity and function of your eye, which is essential information for us to have as we assess your eyes and look for problems. **It is NOT a covered service by Medicare and many other insurance plans. These plans consider the refraction a "vision" service, not a "medical" service.** Our office fee for refraction is **$60.00** and unless your plan automatically covers the refraction charge, this fee is collected at the time of service in addition to any co-payment your plan may require.

Please place your **INITIAL**S on the line below to which your **VISION COVERAGE APPLIES:**

_____ I have vision coverage through **VSP (Vision Service Plan)**

_____ I have vision coverage through **IBEW Local Union 164**

If you **DO NOT HAVE VISION COVERAGE** and still would like the refraction done today, please **INITIAL** below:

_____ I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service and understand that any co-payment, coinsurance, or deductible I may have are separate from, and not included in the refraction fee.
THIS FEE IS COLLECTED AT THE COMPLETION OF YOUR VISIT

If you would like to **DECLINE** the refraction service for today, or would like to **DEFER** the service until your next visit, please **INITIAL** below:

_____ I will decline or defer the refraction service today. I understand that without the refraction, the physicians may not be able to full assess the health and function of my eyes. If you decline the refraction, we will not be able to prescribe new eyeglass or contact lens prescriptions at this time.

Patient Signature:_____ Date:_____

Patient Name: (please print) _____