SWEDBERG EYE CARE

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OPHTHALMOLOGY CLINIC

Refraction Waiver

Refraction is the procedure during which the doctor or ophthalmic technician checks your vision to determine an accurate eyeglass prescription.

Medicare and an increasing number of commercial insurance carriers do not cover refractions. We do not know whether your insurance covers the refraction or not. You can call your insurance company to inquire if refraction (CPT code 92015) is a covered benefit.

Swedberg Eye Care charges $80.00 for refraction and the prescription is valid for 2 years. You can choose not to have refraction performed today. Please be aware that by waiving the refraction today, you will not be able to receive a new eyeglass prescription.

Should you need a new prescription later, you will need to come back to our office to undergo refraction.

I have read the above and elect:

☐ **Not to undergo refraction during my visit today**. I understand that in case I need a valid eyeglass prescription in the future, I will have to come back to undergo refraction.

☐ **To undergo refraction today**. I have read the above information and understand that my glasses prescription is a non-covered service by my Medical insurance.

I accept full financial responsibility for the cost of this service.

Print your name: _____

Signature: _____

Date of Service: _____ MRN:_____

GLASSES PRESCRIPTION (REFRACTION) ACKNOWLEDGEMENT

By signing below you acknowledge that we have informed you of the following:

- Your glasses prescription (refraction) is not covered by Medical insurance.
- We DO NOT bill Vision insurance (VSP, Davis, EyeMed, etc.) plans
- **The fee for a new glasses prescription is $80.00 in addition to whatever copay your insurance company requires for today's visit.**

I have read the above information and understand that my glasses prescription is a **non-covered service** by my Medical insurance.

I accept full financial responsibility for the cost of this service.

I understand that my co-payment for today's office visit is a separate fee per my medical insurance carrier from the refraction fee.

Patient Signature (parent if minor): _____

Date: _____

MRN: _____

Doctor Signature: _____