

**REFRACTION WAIVER**

**WHAT IS A REFRACTION?**

Refraction is the process of determining the eye’s refractive error, or need for corrective glasses and/or contact lenses.

**WHY IS IT SOMETIMES NECESSARY?**

Refraction is sometimes necessary depending on the patient’s diagnosis and/or complaints presented. For example, if a patient is experiencing blurred vision or a decrease in visual acuity on the eye chart, a refraction would be needed to see if this is due to a need for glasses or due to medical problem.

A refraction is also necessary to prove to insurance the need for cataract surgery. We must prove that your vision cannot be simply improved with a glasses prescription.

As you can see, a refraction is an essential part of an eye exam; however, **Medicare and most insurance companies DO NOT cover the charge for a refraction as it is considered a vision-related service versus a medical service.**

**WILL I BE NOTIFIED IN ADVANCE IF I NEED IT?**

Yes, ONLY the doctor or a technician is qualified to tell you if the procedure is necessary. They will let you know if the procedure is necessary BEFORE it is done. You will be given the option to accept or decline this service.

It is important to understand that if you decline, while a diagnostic refraction may be performed to find the source of your vision changes, a glasses prescription will not be released unless you ask for it at your visit.

**HOW MUCH IS THE PROCEDURE?**

Our office policy is to charge $70.00 for this procedure in addition to the office visit co-pay and/or deductible. Payment is due at the time services are rendered. We do not bill vision insurance plans. **As an ophthalmology clinic we are not equipped to carry an optical shop in order to contract with vision plans.**

NOTE: This fee is due and payable whether or not you receive a written glasses prescription. Sometimes the change in vision is not significant enough to warrant the cost of purchasing new glasses. However, the fee covers the doctor’s and technician’s time and effort in achieving this process.

**ACKNOWLEDGEMENT**

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. I understand the co-pay and deductible are separate from, and not included in, the refraction fee.
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Patient Name Patient Signature Date