



Canyon Eye Associates

Refraction Fee Consent and Exam Billing

You are scheduled for an eye exam today with one of our Physicians. For insurance purposes, eye exams fall into two categories, medical and routine vision, and coverage for each varies by insurance policy. The reason for your visit determines how it is billed.

Visit Types

- **Medical Eye Exam:** Diagnosis and treatment of eye conditions such as glaucoma, cataracts, diabetic eye disease, or new symptoms. Medical Exams are scheduled with our Ophthalmologists.
- **Routine Vision Exam:** Determines if your vision can be improved with glasses or contact lenses and screens for eye disease. Vision exams are scheduled with our Optometrist.
- **Refraction:** A test that measures your best corrected vision. You will either be tested by auto-refraction or with a phoropter, an instrument that switches lenses in front of your eyes while you read an eye chart. A refraction is required for a contact lens or glasses prescription. It is considered a vision service and is not covered by Medicare and most medical insurance plans.

How Billing Works

If you are being seen for a medical condition, we bill your medical insurance. If you are being seen for a vision exam, we bill your vision plan (such as VSP or EyeMed); without a vision plan, the exam is paid out of pocket.

Once your insurance is billed, it cannot be reversed, and we cannot bill your medical insurance and your vision plan for the same visit with the same physician on the same day.

If you have VSP or EyeMed and want to use it, please tell us before you see the Ophthalmologist so we can schedule your routine vision exam with our Optometrist.

Canyon Eye Associates' fee for a refraction is \$60.00 and is due at time of service and **cannot be billed**. This is in addition to any co-payment, deductible, or coinsurance required by your insurance plan. The only insurance plans we accept that cover refractions are **MediGold, Aetna Medicare (only), CareSource, and Molina**.

Please check the reason for today's visit:

- ☐ **Medical Eye Exam:** I am being seen for a medical condition. Please bill my medical insurance. I understand I may owe a co-pay, deductible, and/or coinsurance.
- ☐ **Routine Vision Exam:** I have a vision plan and want my exam billed to it. Vision plan: _____
- ☐ **Routine Vision Exam:** I do not have a vision plan. I understand my exam is self-pay and is due at the time of service.
- ☐ **Refraction:** I understand there is a \$60.00 fee that is due at the time of service.

Refraction Request: Do you want to receive an eyeglasses or contact lens prescription today?

☐ Yes, I want a Refraction today. ☐ No, I do not want a Refraction today. Patient's initials: _____

Patient Acknowledgement

I understand how medical and vision exams are billed and that my insurance cannot be changed once billed. I understand that I am responsible for co-pays, deductibles, coinsurance, and any fees my insurance does not cover including the **\$60.00 refraction fee** which cannot be billed to me or my insurance unless I have one of the insurances listed.

Patient Printed Name

DOB

Patient Signature

Date

(Office Use Only)

Vision Plan Check(e.g., VSP, EyeMed): ☐ Plan Found ☐ Plan Not Found Staff Initials: _____