FREDERICKSBURG EYE ASSOCIATES

Anne Pluenneke, MD Charles Cohn, MD

REFRACTION POLICY & ACKNOWLEDGMENT OF RECEIPT

Refraction is a test that determines how much optical error (nearsightedness, farsightedness and/or astigmatism) is present in each of your eyes. During the refraction, a series of trial lenses is placed in front of each eye to determine which combination gives you your best vision. This test determines your glasses prescription. **More importantly, refraction gives your doctor valuable information about your best possible vision and provides essential medical information to help fully assess your eyes and identify problems.** For example, if your vision has declined, the refraction helps your doctor determine if the decrease in vision is due to a need for glasses or from another medical problem. Additionally, refraction is necessary to prove to your insurance company that cataract surgery is necessary.

Refractions will be performed when medically necessary. Typically, we recommend refraction for every new patient, at least once per year for return patients and for anyone with decreased vision.

**We charge $40 for ALL refractions, regardless of whether or not you get a new glasses prescription.** This fee is in addition to any office copay or deductible for which you are responsible, and **is due at the time of service.**

The vast majority of medical/health insurances (including Medicare) do NOT cover the cost of refraction (i.e. it is a "non-covered" service). It is our government (for Medicare) and/or your insurance company (for commercial insurance companies) that determine exactly what services (including refraction) are covered or not covered—not your physician. Some vision plans pay for refraction, but we do not accept vision plans here at this time.

**Note:** Should you decline refraction at your visit, and then you lose or break your glasses we will not be able to provide you with a replacement glasses prescription unless we have a current refraction done here within the past 2 years. Additionally, lack of refraction testing may limit our evaluation of your eyes.

**Acknowledgement:**

**I have read the above information and understand that the refraction may be a non-covered service. I accept full financial responsibility for the cost of the service and understand it is due at the time of service. I understand that any copayment, coinsurance, or deductible I have are separate from and not included in the refraction fee.**

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Signature of Patient or Personal Representative/Guardian Date

_____ _____

Print Name of Patient or Personal Representative/Guardian Date