



## **REFRACTION POLICY**

### ***1. What is a refraction?***

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

### ***2. Why is it sometimes necessary?***

Refraction is sometimes necessary depending on the patient's diagnosis and/or complaints presented that day. 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 a 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 DO NOT cover it.

### ***3. Will I be notified in advance if I need it?***

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

***IMPORTANT: If you decline we may not be able to determine the cause for your decrease in vision.***

### ***4. How much is it?***

Our office policy is to charge **\$47.00** for this procedure in addition to the office visit co-pay and/or deductible. **This is due at the time services are rendered.** We will bill your insurance according to the individual contracted fee schedules. However, if your insurance pays the fee we will gladly refund you this prepaid **\$47.00** amount once we receive notice from your insurance.

**NOTE: This fee is due and payable whether or not you receive a written glasses prescription. Sometimes the change is not significant enough to warrant the cost of purchasing new glasses and new prescription will not be given. However, the fee covers the 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. The co-pay and deductible are separate from, and not included in, the refraction fee.

\_\_\_\_\_  
Patient signature (Parent for minor)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date