



**NOTICE OF NON-COVERED SERVICES**

**EYE EXAM (Refraction) FOR GLASSES**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

The Refraction portion of the eye exam is a test to determine the prescription for glasses. Many medical insurances, including Medicare, consider this exam (Refraction) to be a routine vision service and do not cover the fees. If you choose to have the Refraction and it is not covered by your insurance, the Refraction fee of \$60.00 is your responsibility due at the time of service.

Please select one of the options below.

\_\_\_\_\_ Yes, I want the exam (Refraction) and understand I am responsible for payment if it is not covered by my insurance.

\_\_\_\_\_ No, I do not want the exam (Refraction).

\_\_\_\_\_ I do not want the Refraction at this time, but I may choose to have it at a later date. If so, I may contact my insurance to determine if it will be covered.

The CPT Code is 92015.

Signed \_\_\_\_\_ Date \_\_\_\_\_