Associate Ophthalmologists, P.C.

Vision vs Medical

Patient Name:_____Date of birth_____

VISION EYE EXAM (Routine Visit):
This examination determines if vision can be improved with glasses or contact lenses and basic screening for eye diseases. I understand you bill for routine vision exam:

Patient Signature_____Date_____

MEDICAL EYE EXAM:
This examination for diagnosis and treatment of eye diseases, if glasses or contact lenses cannot improve vision, often the cause is related to underlying medical eye condition.
I understand you bill my medical insurance:

Patient Signature_____Date_____

Refraction:
Refraction is the optical determination of the best possible eye vision. It is needed to determine if any medical, optical, or surgical treatment may be indicated. It is covered by vision insurance.
It is not a covered service by most medical insurance plans.

Do you want an eyeglass and/or contact lens prescription today? (circle) YES NO

If you answered YES you need a refraction. Our office fee for refraction is $50, is collected at time of service, and is in addition to any co-payment. Routine vision sometimes covers this fee.

ACKNOWLEDGEMENT
I have read the above information and understand the refraction may be a non-covered service. I accept full financial responsibility for the cost of this service. The co-pay and deductible are separate from the refraction fee.

_____ _____
Patient Signature (parent for minor) Date