Sight360
Complete Vision Care

REFRACTION

A REFRACTION is the process of determining the need for corrective glasses and / or contact lenses. A refraction is sometimes necessary depending on the patient's diagnosis and / or complaints presented. If a patient is experiencing blurred vision or a decrease in vision on the eye chart, a refraction is needed to determine the need for glasses or due to a medical problem. A refraction I also necessary to prove to insurance the need for cataract surgery. We must prove that you vision cannot be simply improved with a glasses prescription. Therefore, a refraction is an essential part of an eye exam; however, Medicare and most insurance companies DO NOT cover the refraction charge, and you will be notified in advance if a refraction will be performed as part of your examination today. It is important to unde3rstand that if you decline, the doctor may not be able to determine the cause of your decrease in vision.

The refraction charge is **$45.00**, which is in addition to the office visit copay and/or deductible. Payment is due at the time services are rendered. Your insurance company may be billed according to the individual contracted fee schedules, and if insurance pays the fee or a portion of this fee, we will gladly refund the amount due you**. NOTE: This fee is due and payable regardless of whether you receive a written prescription or not.** Sometimes the change in vision is not significant enough to warrant the cost of purchasing new glasses. However, the fee covers the doctor's and technician's time and effort in achieving this process.

I have read the information and understand that the REFRACTION IS A NON-COVERED SERVICE. I accept full financial responsibility for the cost of this service. I understand the copay and deductible are separate from, and not included in, the refraction fee.

_____	_____	_____
Patient Signature (Parent of Minor)	**Patient's Date of Birth**	**Date**

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPPA) POLICY:

I acknowledge that I have been given an opportunity to read a copy of the Pasadena Eye Center's policy relating to the Federal Government's HIPAA privacy regulations and how it relates to patient care. I also acknowledge that I have been given the opportunity to ask questions concerning tis policy. I understand that the staff will be using my first and last name to identify me throughout the office. I give permission for Pasadena Eye Center and / or third-party automated messaging system to contact me or leave a message concerning appointments, treatments, diagnoses, payments and other private health information on my home phone, mobile phone, email address or any other personal contact.

Yes _____ No _____ Please indicate below the names of individuals to whom we may release information contained in your medical chart.

Name: _____Relationship: _____

Name: _____Relationship: _____

By signing this form, I understand and acknowledge the above statements and give Clear Sight Partners consent to release my personal medical information as indicated above.

PATIENT SIGNATURE: _____ DATE: _____