

ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: The doctor will inform you if any of the diagnostic testing below is required. Therefore, you must make a choice to either receive or decline the services. In terms of coverage, be aware that the insurance will **not** pay **all health care costs**. Your insurance **only** pays for the services if your **deductible and out of pocket has been met**. It is also the office's policy to collect the contribution amount from you if the **deductible and out of pocket has not been met**. If the insurance does pay the full amount, the office is required to refund the amount paid. We will notify you through phone or mail.

In addition, although your insurance may not cover particular services and items, these procedures are **highly recommended** by our doctors to ensure optimal health.

As a courtesy, the office will call your insurance to check your benefits. However, it is your responsibility to know your insurance requirements pertaining to coverage and referral needs. The terms of your insurance coverage are between you and your insurance company. Therefore, any questions or concerns you may have should be directed to your insurance company.

Common procedures that may not be covered by insurance (\$)			
REFRACTION	5.00	CORNEAL TOPOGRAPHY	45.00
MPOD	39.00	SPECULAR TOPOGRAPHY	155.00
PHP	80.00	EXTENDED MICROSCOPY	65.00
EXT. PHOTOS	45.00	VISUAL FIELDS	99.00

Please check the appropriate box.

- Option 1. **YES** – I allow the office to submit the comprehensive eye exam and any diagnostic services required to my insurance and anything **not covered** will be billed to me. I also accept the terms stated above.

- Option 2. **NO** – I do **not** allow the office to submit the comprehensive eye exam and any diagnostic services to my insurance. I understand that I will pay for any services **in full**.

X

Signature of patient or person acting on patient's behalf Date

Primary Insurance Information

Secondary Insurance Information

Insurance Name: _____
 Insurance ID # _____
 Insurance Group # _____

Insurance Name: _____
 Insurance ID # _____
 Insurance Group # _____

PRIMARY INSURED INFORMATION

 Last Name First Name Middle Initial DOB: ____/____/____

 Insured's Address Street City State Zip Code

 Phone Number Sex: M F CIRCLE ONE: Self Spouse Child Other

X

Signature of patient or person acting on patient's behalf Date