Refraction Policy Acknowledgement

It is important to understand that the **REFRACTION evaluation is an essential part of your comprehensive eye examination**. It is used to determine each eye's best corrected visual acuity; both for determining a formal eyeglass prescription as indicated, and also diagnostically for identifying the visual acuity potential relative to certain eye diseases and conditions, i.e. diabetes, cataracts, macular degeneration, keratoconus, etc.

Information gained from all aspects of your comprehensive eye examination, including the refraction and a thorough dilated evaluation of the eye's internal structures or the Optomap, the non-dilating camera that captures a digital image of the retina , is what allows your optometrist to have the full picture of your eye's health status. These are vital components that optimize their overall medical assessment for making the best possible determination of your most effective treatment options.

The out-of-pocket cost for the refraction service is $40. Unfortunately, despite the significant diagnostic value of the refraction, most insurance carriers, including Medicare , see the service only for its prescription benefit and deem it as a routine, non-covered vision service under your medical coverage.

If you have a routine vision plan as part of your health benefits, you could file the refraction, and any additional eyeglass or contact lens related costs (with copies of your paid receipts) for possible reimbursement from your insurance company.

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I have thoroughly read the above information and have had any questions concerning the refraction policy answered to my satisfaction. I further acknowledge that this signed document will remain a part of my permanent record and apply to any future refraction charges that I may incur as a part of my comprehensive eye examination.

Please check one of the two selections and sign:

☐ My signature below indicates that I agree to receive the refraction service as medically advised and I accept full financial responsibility for this charge if it is not covered by my insurance.

☐ My signature below indicates that I refuse to receive the refraction service, despite medical advice. I understand that without this information, I will not receive a prescription for eyeglasses or contact lenses.

Print Patient Name: _____ Date: _____