CHESTERFIELD OPHTHALMOLOGY

REFRACTION POLICY ACKNOWLEDGMENT

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 glasses prescription as indicated, and also diagnostically for identifying the visual acuity potential relative to certain eye diseases and conditions, i.e. diabetes, cataracts, keratoconus, macular degeneration, 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, is what allows Dr. Busch the full picture of your eyes' health status. These are vital components that optimize his 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 $45. Unfortunately, despite the significant diagnostic value of the refraction, most insurance carriers (including Medicare, Caremore and Humana) 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 a part of your health benefits, *you* could file the refraction, and any additional contact lens or glasses related costs (with copies of your paid receipts) for possible reimbursement.

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 exams under Dr. Busch's care.

Please check one the two selections and sign.

☐ My signature below indicates that I agree to receive the refraction service as medically advised by Dr. Busch. 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 advisement. *I understand that without this information, Dr. Busch cannot accurately determine my best visual potential and will be unable to cover or discuss ways to correct my vision and provide all of my treatment options.*

_____ _____

Patient or Guarantor Signature Date