RICHARD J. MANGANIELLO, MD

REFRACTION BILLING POLICY FOR ALL PATIENTS

PLEASE SIGN AND RETURN TO OFFICE

To my patients:

REFRACTION is the process of determining refractive error and is done for diagnostic purposes as well as for establishing any need for corrective lenses (eyeglasses). This is an essential part of an eye examination and is done during a complete medical eye exam as a standard of responsible care. Unfortunately, Medicare and many commercial insurance carriers choose not to cover this service, even while recognizing the need for it.

The patient fee for refraction is $40.00 if your insurance plan does not cover this service. This fee is *in addition to* any co-pay, co-insurance, or deductible required by your insurance. In order to keep billing costs down**, we will ask for refraction payment at the time of your appointment if it is not a covered service under your insurance plan.**

The fee for a complete, updated contact lens prescription is also $40.00. This service is provided for those patients who are happy with their current brand of contact lenses and wish to have the fit, prescription strength, and suitability checked so that contact lens refills can be ordered locally or online. You will need to wear your current contact lenses in for the exam and bring the boxes that have the measurements printed on them. **This fee is not covered by medical insurance plans and will be collected at the time of service.**

My office staff and I will be happy to answer any questions regarding this policy.

Thank you,

Richard J. Manganiello, MD

CEPS 12-09-19

☐ ALL PATIENTS: I have read the above information and accept full financial responsibility for the $40.00 patient refraction fee should my insurance plan not cover the service, which may be collected at the time of service if the office staff knows in advance that my plan will not cover it.

☐ CONTACT LENS PATIENTS: I understand that there is an additional $40.00 fee payable at the time of service if I wish to obtain a complete, updated contact lens prescription.

I understand that these fees are in addition to any and all co-pays, co-insurances, and deductibles.

Patient Signature: _____ **Date:** _____

Patient Name (printed): _____

If signed by someone other than the patient, please print name and relationship to patient:

_____