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	**50.00**	**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

Insurance Name: ______________________

Insurance ID #_________________________

Insurance Group #______________________

Secondary Insurance Information

Insurance Name: ______________________

Insurance ID # ________________________

Insurance Group # _____________________

PRIMARY INSURED INFORMATION

____ **DOB:** _____/______/_____

Last Name **First Name** **Middle Initial**

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**