

MANHATTAN VISION ASSOCIATES
160 East 56th Street, Suite 300
New York, NY 10022
212-688-4277

I understand that I am responsible for any co-payments that are linked to my examination and/or glasses/contact lens benefit through my vision insurance.

I also understand that medical testing may be necessary and will be billed to my medical insurance (e.g. diagnostic imaging and testing for ocular disease such as glaucoma, cataracts, etc.) I understand that I am responsible for any co-payments, co-insurances, and/or yearly deductibles that are linked to my medical insurance.

If I do not have separate vision insurance and my major medical does not cover the refraction for my glasses, I understand that I am responsible for payment for the refraction and will be billed accordingly.

Name _____

Date _____

Signed _____