ADVANCE BENEFICIARY NOTICE

Please be advised a routine eye exam for many, but not all insurances includes a history, refraction, basic eye structure health and function check, glaucoma pressure check and dilated or undilated view of the inside of the eye. It does not include a contact lens evaluation, dry eye exam, visual field, photographs or digital imaging. These tests are a separate fee and/or exam and may or may not be covered by your insurance.

I agree to have the following tests/exam and agree to pay the fee. If the charge is submitted to my insurance and paid to the provider the amount of that payment will be reimbursed.

Dry Eye Initial Evaluation/Follow Up	105/65	_____
Demodex Treatment	85	_____
Manual Meibomian Gland Expression	40	_____
Lipiflow	750	_____
Topography/meibography	20	_____
Iwellness	20	_____
OCT	55	_____
Visual field	60	_____
Fundus Photography	75	_____
Medicare does not pay for refractions and as part of a routine or medical exam the patient is responsible for that charge	45	_____

I agree to the following tests and agree to the payment charged

Name_____

Signature _____

Date ___/___/_____