Atlanta Ophthalmology Associates

Refraction, Contact Lens Fees, Dilation

Initial

Patient Acknowledgement Regarding Refraction Fee

☐

A "Refraction" is a test which determines a person's need for eyeglasses. It is a service NOT covered by Medicare or most medical insurance plans.

If you have a medical diagnosis (such as cataract, dry eye, glaucoma, etc.), your exam is usually covered by your regular medical insurance. If you would like for us to check and update your eyeglasses prescription, then the refraction will be done. Our fee for this service is due at the time of your service. As a courtesy, we will bill your medical insurance. Should your plan pay us, we will reimburse you accordingly. The fee is up to $50.00 depending on the reason and complexity of your prescription.

Initial

Patient Acknowledgement Regarding Contact Lens Evaluation Fee

☐

Contact lens patients require additional testing which is not included in a routine eye exam. This is to insure that your contact lenses are still properly fitting and providing you the highest quality of vision, health and comfort.

There is an annual contact lens examination fee which is due at the time of service. The fee can vary greatly depending on the complexity of the lens you wear. Most insurance companies do not cover these additional professional services. Office estimate $75 - $175 (excludes scleral lens fits).

Contact lens prescriptions expire yearly and renewals are not allowed after **1 year** without an examination.

Initial

Patient Acknowledgement Regarding Dilation

☐

During your examination, it may be necessary to dilate your pupils. Dilation results in light sensitivity and blurring of your near vision. These side effects typically last between 3 to 5 hours. To reduce light sensitivity following dilation, a pair of disposable sunglasses will be given to you if you do not bring your own.

I have read and understand the above information. I accept full financial responsibility for the cost of refraction and/or contact lens evaluation if provided and if not covered by my insurance. I understand that any co-payment or deductible would be separate from and not included in either the refraction or contact lens fee.

_____ _____

Patients Name Date

_____

Signature of Patient or Parent/Guardian