WELCOME TO OUR OFFICE
CONNECTICUT VISION ASSOCIATES PLEASE HELP US KEEP OUR RECORDS UP TO DATE

PATIENT RESPONSIBILITY FORM

I UNDERSTAND THAT WITH CURRENT AND FUTURE CHANGES IN THE INSURANCE INDUSTRY THAT MY BENEFITS MAY CHANGE FROM YEAR TO YEAR. I UNDERSTAND THAT WHAT MAY HAVE BEEN COVERED PREVIOUSLY MAY NO LONGER BE THE CASE GOING FORWARD. IT IS MY RESPONSIBILITY AT THE TIME OF MY EXAM TO LET THE STAFF KNOW IF I AM ELIGIBLE FOR ANY ROUTINE EYE CARE BENEFITS OR HAVE AN EYE CARE SUPPLEMENTAL POLICY, I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO KNOW AND UNDERSTAND MY POLICY AND NOTIFY MY PCP IF A REFERRAL IS REQUIRED. I UNDERSTAND THAT IF MY EXAM APPLIES TOWARDS MY DEDUCTIBLE, I WILL BE HELD RESPONSIBLE FOR THE BALANCE.

YOUR INSURANCE MAY HAVE INDICATED THAT YOU ARE ENTITLED TO AN ANNUAL OR BIANNUAL ROUTINE COVERAGE, IF THERE IS A MEDICAL CONDITION THAT BECOMES EVIDENT DURING YOUR VISIT OR YOU ARE RETURNING WITH A PRE-EXISTING CONDITION (SUCH AS DRY EYE, GLAUCOMA, CONJUNCTIVITIS, DIABETES, HIGH BLOOD PRESSURE), THIS MAY REQUIRE A MORE EXTENSIVE EXAMINATION AND/OR TREATMENT. IN THIS CASE, YOU WILL NEED YOUR EXAM SUBMITTED TO YOUR MAJOR MEDICAL.

I HAVE READ THE ABOVE POLICY AND I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, AFTERIF PAYMENT IS MADE BY MY INSURANCE. IN ADDITION, I HEREBY ASSIGN ALL MEDICAL VISION BENEFITS WHICH I AM ENTITLED, INCLUDING MEDICARE, PRIVATE INSURERS, AND OTHER HEALTH PLANS TO CONNECTICUT VISION ASSOCIATES.

PRINT YOUR NAME: ____DATE:_________________

SIGNATURE:____

MEDICARE ELIGIBLE PATIENTS ONLY

ADVANCE BENEFICIARY NOTICE OF NON-COVERAGE (ABN) NOTE: IF MEDICARE DOESN'T PAY FOR THE SERVICE LISTED BELOW, YOU MAY HAVE TO PAY. MEDICARE DOES NOT PAY FOR EVERYTHING, EVEN SOME CARE THAT YOU OR YOUR HEALTH CARE PROVIDER HAVE GOOD REASON TO THINK YOU NEED. WE EXPECT MEDICARE NOT TO COVER FOR THE SERVICE BELOW:

Service	**Reason Medicare May Not Pay**	**Estimated Cost**
REFRACTION – THE DETERMINATION OF YOUR EYE GLASS PRESCRIPTION BY THE DOCTOR.	MEDICARE DOES NOT CONSIDER THIS PART OF THE EXAM MEDICALLY NECESSARY.	$65.00

PLEASE SELECT AN OPTION BELOW:

- ❑ OPTION 1 - I WANT THE SERVICE LISTED ABOVE. I AM AWARE THAT MY INSURANCE MAY OR MAY NOT COVER THIS LINE ITEM AND I WILL BE RESPONSIBLE FOR THIS AMOUNT IF NOT COVERED BY MY INSURANCE POLICIES.

- ❑ OPTION 2 - 1 DECLINE THIS SERVICE LISTED ABOVE. I UNDERSTAND WITH THIS CHOICE, I AM NOT RESPONSIBLE FOR THIS PAYMENT AND WILL NOT BE ABLE TO OBTAIN AN UPDATED PRESCRIPTION FOR MY EYE GLASSES UNLESS THIS SERVICE IS PERFORMED.

  ______________INITIAL IF APPLICABLE

YEARLY CONTACT LENS EVALUATION - $60.00 OUT OF POCKET EXPENSE

AS A WEARER OF CONTACT LENSES, IT IS MEDICALLY NECESSARY FOR THIS OFFICE TO EVALUATE THE

CONTACT LENSES AND CORNEAL INTEGRITY. THIS CONSISTS OF:

- CORNEAL TOPOGRAPHY AND MAP TO CHECK FOR IRREGULARITIES
- EVALUATE THE CONTACT LENSES ON THE EYE (CHECK FOR MOVEMENT AND POSITION)
- FLUORESCEIN, A YELLOW DYE THAT IS APPLIED TO THE EYE TO MONITOR CORNEAL INTEGRITY
- CHECK REFRACTION OVER THE CONTACTS TO DETERMINE THE POWER OF THE NEW CONTACTS

_____________INITIAL IF APPLICABLE