Weill Cornell Medicine
NewYork-Presbyterian

Ophthalmology
Tel: 646-962-2020 Fax: 646-962-2020

1305 York Avenue
New York, NY 10021

www.weillcornelleye.org

Notice of Non-Covered Refraction Services

EYEGLASS OR CONTACT LENS PRESCRIPTION (REFRACTION)

Thank you for choosing us as your healthcare and vision specialists. During your visit, a refraction may be performed to obtain the most appropriate optical determination. A refraction is a necessary part of the exam if an eyeglass or contact lens prescription is to be issued. In addition, refractions can assist in determining if other medical, optical or surgery treatment may be indicated. We want to be sure to notify you in advance that most health insurance companies have determined this service is **not** part of their medical plan policies and therefore **not a covered service**. If you are not aware of your specific plan's policy, we encourage you to contact your health insurance company directly. However, payment for all refractions are expected at time of service. **Init.**_____

If you would like to receive a prescription for eyeglasses today, you will be charged the standard fee of **$75.00** which will be collected when you check out. In rare circumstances, a refraction is a required part of your exam to determine if other treatments are necessary. Once performed you will be asked to pay this $75 fee at check-out. *Please note*, the determination of your prescription may lengthen your visit. Occasionally, an insurance plan may cover an eyeglass prescription/refraction, although this is infrequent and highly variable. If this occurs, we will quickly reimburse your payment via a check mailed to your home address. _____

***Special Note to New Patients**: If you have never been examined by a provider at Weill Cornell Eye Associates, it is mandatory to obtain a comprehensive exam in addition to the refraction. The comprehensive exam can be waived if you have recently been examined by an outside provider and can provide the appropriate clinical documentation. This service is associated with additional fees. (Be aware that not all our providers participate with the same plans; please be sure to ask anyone at the front desk about your insurance plan and how this may impact your financial responsibilities). **Init.**_____*

***Special Note to ALL Patients:** Refractions are **Non-Refundable**. Any resulting eyeglass prescriptions must be filled right away. Should you have any concerns with your prescriptions resulting from discrepancies with your refraction, we must be notified within 60 days of the service date **Init.** _____*

If you are interested in a contact lens prescription or evaluation, you will be referred to our contact lens specialist (optometrist) on a different day. For more information about contact lens fitting fees, please read the second page of this notice.

Please sign and check the acknowledgement below:

I have read the above information and understand the following:

- *The eyeglass prescription / refraction are non-covered services and are associated with a $75.00 self-pay fee.*
- *If it is a necessary part of my exam, we will perform the refraction and you will be asked to pay the $75 self-pay fee at check-out.*
- *The determination of my prescription may lengthen my visit for a longer than usual exam.*
- ___*Yes, I am interested in contact lenses and would like a new or updated prescription. If you checked this box you will be referred to our contact lens specialist.*

*Print Name:*_____*Today's Date:* _____

Signature: _____

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FINANCIAL POLICY AGREEMENT

We would like to thank you for choosing Weill Cornell Eye Associates as your healthcare provider. We consider it an honor and privilege to participate in your care.

Understanding your financial responsibilities and expectations will save you worry and stress later. If you have any questions or concerns about our payment policies, please ask to speak with a member of our billing staff either by phone (646-962-2020) or in person.

It is important that you read this policy carefully before you receive treatment. Payment is required at the time services are rendered. This includes applicable coinsurance, deductibles, and copayments for participating insurance companies as well as payment for all services not covered by insurance. ***Examples of known non-covered services include refractions (eyeglass and contact lens prescriptions) as well as prism lenses.*** Our practice will accept cash, check, debit cards, Visa, MasterCard, Discover and American Express. Init._____

We are legally required to collect your co-pay & deductible.
The Health Care Financing Administration (otherwise known as HCFA) is the federal government agency responsible for setting policy and overseeing the Medicare and Medicaid programs. HCFA has mandated that physicians and other providers of health care must collect co-pays, deductibles and co-insurances. This is enforced by the Office of the Inspector General (OIG). Init._____

Co-payment Processing Fee Policy
Co-payments are due at time of service. If you would like us to bill you (or if copays are not paid at time of service), you will be charged a $10 processing fee. Init. _____

24 Hour Cancellation & "No Show' Fee Policy.
Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, we reserve the right to charge a fee of $75 for all missed appointments ("no shows") and appointments which, absent of a compelling reason, are not cancelled with a 24-hour advance notice. Init. _____

We understand that things do happen, and financial problems may affect your ability to pay the bill in full. We will always do everything we can to work with you. However, we ask that you contact us as soon as possible to work out an arrangement that is satisfactory for everyone.

We appreciate your faith and trust in us and thank you for the opportunity to serve your healthcare needs.

Assignment and release: I authorize payment to be made directly to the Weill Cornell Medical College Department of Ophthalmology and fully understand that I am the responsible party for all charges incurred by me or my dependents at this facility. I also authorize the release of any and all information required to collect and process my claims.

Refusal to Initial and/or Sign this document does NOT remove your financial responsibility and/or obligations to its contents

*Print Name:*_____ *Today's Date:* _____

Signature: _____ CONTINUED ON BACK ---->

Thank you for choosing Weill Cornell Eye Associates as your eye care provider!

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If you have a Medicaid or Medicaid Managed Care Plan, please complete this form

Medicaid Waiver Form for Refraction Services and Prism lens

Patient Name: _____

MRN Number: _____

Medical Insurance Plan: _____

I understand that the servicing provider may be required to perform a **refraction** and/or distribute **prism lens/s** to obtain the most appropriate optical determination. A refraction may be a required part of my exam to determine if other treatments are necessary. A prism lens may be required to correct vision abnormalities and aid in my eyes working together.

I voluntarily agree and consent to undergo the services and/or handling of lens, as a private paying patient. I agree to waive my Medicaid and/or Medicaid Managed Care Plan benefits for refraction services and/or prism lens during the period of my care with Weill Cornell Ophthalmology. I will be responsible for paying the refraction and/or Prism lens fee at time of service or any refraction and/or Prism lens balances accrued thereafter.

- **Refraction (92015) - (Determination of refractive state) for the prescription required for eyeglasses or contact lenses - $75**
- **Prism Lens (V2718) – Press-on lens, Fresnel Prism, per lens - $75**

Anticipated Services date: _____

I understand that the $75 refraction fee and/or the $75 Prism Lens fee is my responsibility and I am expected to pay this amount today, before I conclude this visit (initial) _____

Signed: _____ Date: _____

Witness: _____ Date: _____

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If you have a HMO Plan, please complete this form

HMO Insurance Referral Waiver Form

Patient Name: _____

Medical Record Number (MRN): _____

Insurance: _____

Date of Service: _____

"I understand that the services provided by the Weill Cornell Eye Associates Department are not eligible for reimbursement by my HMO Health plan without a valid referral from my primary care provider."

I voluntarily agree and consent to undergo the services, as a private paying patient. I agree to waive my in network Managed Care Plan benefits for the period of my care with Weill Cornell Eye Associates. I will be responsible for paying all services I receive at time of service or any balances accrued thereafter. The provider will only file a claim to my HMO Managed Care plan in the event I am able to obtain a valid required referral in a timely manner with the correct referral information, such as; **correct date of service**, **insurance authorization number**, **correct billing provider**, and **number of visit/s.**

Patient Signature: _____ Date: _____

Witness: _____ Date: _____