EMPIRE EYE
PHYSICIANS
EmpireEye.com

COEUR D'ALENE OFFICE
2175 N. Main St. (Riverstone), Coeur d'Alene, ID 83814
Phone (208) 664-9888 | Fax (208) 666-0816

SPOKANE VALLEY OFFICE
1414 N. Houk Rd., Suite 103, Spokane Valley, WA 99216
Phone (509) 928-8040 | Fax (509) 928-0784

Acknowledgement of Refraction Policy

A refraction diagnostic evaluation is an important part of an eye exam. The refraction is essential medical information to determine the health of the eyes. Refraction services provide the following information:

Diagnostic: Refraction is how physicians determine the best possible visual acuity and function of the eye and diagnose underlying medical conditions pertaining to the eyes. Physicians use refraction results to compare changes in vision between appointments.

Prescriptions: Refraction testing generates a prescription for glasses and contacts. Refraction can determine whether patients can be helped with updated glasses or contacts prescription either before or after any eye surgery, or when they have experienced a vision change. The refraction diagnostic evaluation is not a service covered by Medicare and most other medical insurance plans. These plans consider refraction to be a "vision" service, not a "medical" service.

If a refraction was performed at Empire Eye Physicians as a diagnostic part of a medical exam, cataract evaluation or surgery evaluation, patients may or may not be charged for this testing. If the refraction is requested as a new prescription for glasses, Empire Eye Physician's fee is $60. Unless a patient's insurance plan covers the refraction fee, a fee of $45 (a 25% discount) is discounted if collected at the time of service in addition to any co-payment an individual's insurance plan may require. Should the insurance plan pay for all or part of the refraction fee, Empire Eye Physicians will reimburse the patient accordingly.

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service and understand it is due at the time of service. I understand that any co-payment, coinsurance or deductible I may have are separate from and not included in the refraction fee.

_____

Patient Name (Print)

_____ _____

Patient Signature Date