

ADVANCED BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care items or services. We expect that your insurance company (including Medicare) may not pay or will only pay a portion of the cost for the item(s) or service(s) that are described below. Your insurance (including Medicare) does not pay for all of your healthcare cost. Your insurance (including Medicare) only pays for covered items and services when coverage rules are met. The fact that your insurance (including Medicare) may not pay or will only pay a portion of the cost of a particular item or service does not mean that you should not receive it. There maybe a good reason your doctor recommended it. Right now, in your case, your insurance (including Medicare) may not pay for all of the cost for

Items or Services: Refraction

Reason: Either the refraction is not a covered benefit of your insurance coverage or your benefits may only cover a portion of the cost for the item(s) or services you chose.

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, **you should read this entire notice carefully.**

- Ask us to explain, if you don't understand why your insurance or Medicare probably won't pay.
- Ask us how much these items or services will cost you. (**Estimated Cost: \$40**) in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. SIGN & DATE YOUR CHOICE

OPTION 1. YES, I want to receive these items or services.

I understand that my insurance (including Medicare) will not decide whether to pay unless I receive these items or services. Please submit my claim to my insurance (including Medicare). I understand that you may bill me for items or services and that I may have to pay the bill while my insurance (including Medicare) is making its decision. If my insurance denies payment, or does not pay for the full cost, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I may have. I understand that I can appeal my insurance's (including Medicare) decision.

OPTION 2. NO, I have decided not to receive these items or services.

I will not receive these items or services. I understand that you will be able to submit a claim to my insurance (including Medicare) and that I will not be able to appeal your opinion that my insurance or Medicare won't pay.

Print Patient's Name

Patient's Signature or person acting
on patient's behalf

Date

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential and in our office. If a claim is submitted to your insurance, your health information maybe shared with your insurance company. Your health information, which your insurance sees, will be kept confidential by your insurance company.



Physician