**Vision Exclusion Form**

**Refraction** is the vision test to determine your eye glass prescription ONLY. This test is a **VISION TEST** and **NOT** covered by **MEDICAL INSURANCE.**

**This is NOT an exam for Contact Lenses.**

The **$35.00** fee for this testing is not covered by Medicare and most Managed Care Insurance Plans. For patients with **AFFINITY, AMERIGROUP, FIDELIS, HEALTHFIRST, METROPUS**, **UNITED HEALTHCARE** (Oxford not included) **AND WELLCARE** we will bill your insurance carrier **FIRST.**

If my insurance carrier does not pay for the refraction, I personally agree to be responsible for payment**.** For all other insurance carriers, payment is required at the time of service.

**Medical insurance will cover medical testing only!**

**I WISH TO HAVE THE VISION TEST AS PART OF THE EXAMINATION**

**I understand that payment is due on the date of service.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of patient** **Date**

**I DO NOT WISH TO HAVE THE VISION TEST AS PART OF THE EXAMINATION**

**I understand that by signing below I will not have the test done for a prescription for glasses. The Doctor will only be able to tell me what my visual acuity is with my current glasses.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of patient**  **Date**