ADVANCE BENEFICIARY NOTICE OF NON-COVERAGE (ABN)

Date: _____

Patient Name: _____

Insurance: _____

- You are receiving this notice because your insurance company may not pay for all of the services that you receive during your visit to our office.

WHAT YOU NEED TO DO NOW

- Read this notice so you can make an informed decision about your care.
- Ask questions.

Services/Procedures/Supplies	Reason Your Insurance May Not Pay	Estimated Cost
Refraction for Glasses 	Not a Covered Benefit On Medical Plans. If we are using a vision plan *only* it will be a covered charge. Many times the refraction needs to be done to check your visual state to verify if you can see sufficiently with spectacle lenses or if you need to have cataract surgery as an example.	$25.00
Contact Lens Fitting (New Fit)	Not a Covered Benefit Unless you have a Vision Plan (VSP, MES, etc.)	$40.00 - $80.00
Yearly Contact Lens Annual Update	Not a Covered Benefit Unless you have a Vision Plan (VSP, MES, etc.)	$40.00

_____Yes, I want to receive these services. If my insurance carrier denies payment, I am completely responsible for payment in full. I understand that I can appeal this decision for non -payment with my insurance carrier.

_____ No, I have decided not to receive these services.

By signing this notice, you agree to take financial responsibility for the cost of the supplies and or services listed above should your insurance company deny coverage for listed items.

Guarantor Signature: _____Date: _____