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Advance Beneficiary Notice (ABN) -

NOTE: You need to make a choice about receiving these health care items or services.
We expect that Insurance may not pay for the item(s) or service(s) that are described below. Insurance does not pay for all of your health care costs. Insurance only pays for covered items and services when Insurance rules are met. The fact that Insurance may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Insurance may not pay for some of the following items or services:

Items or Services:

- Contact Lens, as well as Fits & Mini Fits
- Punctual Plugs
- Refraction
- Routine Examination/ Complete Eye Exam
- Some surgeries – Premium Implants
- Some Testing – OCT's, Visual Fields, Topography, Pachymetry, OPTOS Fundus Photos

Reasons Insurance not pay

- Deductible
- Not Covered
- No Referral

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.

Please choose ONE option. Check ONE box. Then Sign & Date Your Choice.
If you do not select Option 1 or Option 2 then Option 1 will be assumed as your choice.

☐ **Option 1.** *Yes, I understand that it will be my responsibility to pay for any items or services that insurance does not pay for.*

I understand that Insurance will not decide whether to pay unless I receive these items or services. Please submit my claim to insurance. I understand that you may bill me for items or services and
that I may have to pay the bill while Insurance is making its decision. If insurance does pay, you will refund to me any payments I made to you that are due to me. If insurance denies payment, 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 have. I understand I can appeal insurance's 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 not be able to submit a claim to insurance and that I will not be able to appeal your opinion that insurance will not pay.

______________________________ ______________________________

Patient's Name **Signature of patient or person acting on patient's behalf**

______________________________ ______________________________

Insurance **Date**

Note: Your health information will be kept confidential. Any information that we collect about on this form will be kept confidential in our offices. If a claim is submitted to insurance, your health information which insurance sees will be kept confidential by insurance.