Diane Hilal-Campo MD

Patient Acknowledgement Regarding

Refraction Service and Fee

√ A refraction is the process of determining your best corrected vision and if there is a need for corrective eyeglasses or contact lenses. It is an essential part of an eye examination and is necessary to write a prescription for glasses and is a pre-requisite for contact lens fitting.

√ A refraction is NOT a covered service by Medicare or most insurance plans. These plans consider refraction a “vision” service, not a “medical” service. Please let us know if you have a separate vision plan.

√ Our office fee for refraction is collected at the time of service in addition to any copayment your plan may require. **Our fee for the refraction is $ 85.00**

Precautions following Dilation

It may be necessary to dilate your eyes during the course of your eye examination or treatment. Dilation results in sensitivity to light and an inability to see well at close range or distance for a few hours. We provide free disposable sunglasses or dark sunglass inserts. Patient should wear sunglasses and be cautious walking, going up or down stairs, as well as driving immediately afterwards.

The office will try to do an **Optos** scan to avoid dilation when possible. This will provide the doctor with a scan of the retina to confirm the health of your eye.

Our office fee for Optos is collected at the time of service in addition to any copayment your plan may require. **Our fee for the Optos is $60.00**

Contact Lens Evaluation and Fee

√ If you are having an eye examination and wear contact lenses, our professional staff will be evaluating your current contact lenses to determine their current status. The fee for this service is collected in addition to the fee for an eye examination without contact lenses**.**

Yearly contact evaluations are $ 60.00 for standard spherical contacts and $75 for toric or multifocal contacts.

I have read and understand the above information. I accept full financial responsibility for the cost of a refraction and/or contact lens evaluation, if provided, and understand payment is due at time of service. I understand that any copayment, coinsurance or deductible I may have are separate from and not included in either the refraction fee or contact lens evaluation fee.

_____________________________ ____________________ _______________________________

Patient’s Name (printed) Date Relationship to Patient

____ _______________________________

Patient’s Signature (Legally Responsible Adult for minor) Staff Witness