F.A. HAUBER, M.D., P.A.
d/b/a Pasco Eye Institute

Frederick A. Hauber, M.D., F.A.C.S.
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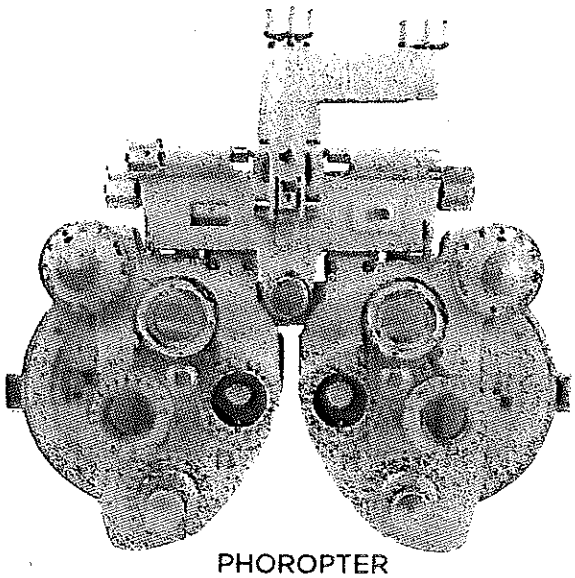
REFRACTION

Better 1

or

Better 2?

The **ONLY** way we can sort out whether reduced vision is a matter of a simple eyeglass adjustment or some other problem is to perform a **REFRACTION**, which measures the eyes' focusing ability. This is the familiar "better one or better two?" part of the exam where you look at the eye chart through the **PHOROPTER** (see picture below).



PHOROPTER

The rest of the eye exam, **THE MEDICAL EYE EXAM,** determines if there are other disorders or conditions that are causing difficulties.

BOTH THE REFRACTION AND THE MEDICAL EYE EXAM ARE ABSOLUTELY NECESSARY TO FULLY EVALUATE THE HEALTH OF YOUR EYES AND VISUAL SYSTEM.

Why am I being charged a refraction fee?

Medicare and most other insurers will not pay for this vital part of the eye exam and will only reimburse for **THE MEDICAL EYE EXAM** component. The **REFRACTION** component has been made the patient's responsibility.

ACKNOWLEDGEMENT

I have read the above information and I understand that the refraction is a non-covered service. I accept full responsibility for the cost of this service. The co-pay and deductible are separate from, and not included in, the refraction fee of $40.00. I agree I will pay for services rendered the day they are performed.

Patient Signature (Parent for Minor) _____ Date _____

5347 Main Street, Suite 100 • New Port Richey, FL 34652 • Tele. (727) 847-4448 Fax (727) 845-1572
Visit us on the internet: http://www.pascoeye.com
Member: Diabetic Eye Centers of America, Inc.

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Signature on File, Assignment of Benefits, Financial Agreement

Patient Name: _____

1. **Medicare:** I request that payment of authorized Medicare benefits be made on my behalf to Pasco Eye Institute for services furnished me by Pasco Eye Institute. I authorize any holder of medical information about me to release to the payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Pasco Eye Institute accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.
2. **MEDIGAP:** I understand that if a Medigap policy or other health insurance is indicated in the Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Pasco Eye Institute.
3. **RELEASE OF INFORMATION:** Pasco Eye Institute may disclose all of any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV to any person or corporation (1) which is or may be liable or under contract to Pasco Eye Institute for reimbursement for services rendered, and (2) any health care provider for continued patient care.
4. **OTHER INSURANCE:** I understand that Pasco Eye Institute maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Pasco Eye Institute if I belong to a plan that does not appear on the above mentioned list.
5. **NON_COVERED SERVICES:** I understand that Pasco Eye Institute contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services which are "covered" by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. I understand that if I have a managed care plan, I will be held accountable for payment if I did not obtain a referral for my visit. **The following insurance companies do not cover routine eye care:** Medicare, Metropolitan Empire, No Fault, some Blue Cross Blue Shields, some United Healthcare, Some Cigna, some Aetna, GHI.The fee for a routine eye examination with an Ophthalmologist is $150.00 and a routine eye exam with the Optometrist is $110.00 (the refraction is included). This is a fully dilated exam to check the health of your eyes and a refraction to determine your eye prescription.
6. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by Pasco Eye Institute, I will pay my account at the time service is rendered or will make financial agreements satisfactory to Pasco Eye Institute for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance, insuring the patient, or any other party liable to the patient, are hereby assigned to Pasco Eye Institue. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Pasco Eye Institute. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

_____ _____

Patient Printed Name & Signature or Authorized Party Date

PAYMENT FOR APPLICABLE CO-PAYMENT, DEDUCTIBLE, OR NON-COVERED SERVICE ARE DUE ON THE DAY OF SERVICE.
THERE WILL BE A $25.00 FEE ASSESSED IF PAYMENT IS NOT MADE ON THE DATE OF SERVICE.
THANK YOU FOR YOUR COOPERATION.