

The Eye Center

Medical & Surgical Eye Care

Laura Muller M.

727-216-2020

ACKNOWLEDGEMENT OF NON-COVERED SERVICE (Refraction 92015)

Please read the appropriate section that applies to the type of medical coverage you are insured under, then initial and sign the bottom.

Section: For Commercial Insurance policyholders:

Please be advised that based on current insurance guidelines the following MAY NOT BE COVERED under your medical plan and may be denied; therefore, I acknowledge and accept responsibility for payment of this service. Please initial: _____

Section: For Universal Healthcare policyholders ONLY:

Please be advised that based on Universal guidelines the following is a NON-COVERED SERVICE when in conjunction with a medial diagnosis; therefore, I acknowledge and accept responsibility for payment of this service. Please initial: _____

Section: For Medicare Part B beneficiaries ONLY:

Please be advised that based on Medicare guidelines the following is a NON-COVERED SERVICE; therefore, I acknowledge and accept responsibility for payment of this service. Please initial: _____

<u>Service Date</u>	<u>Procedure Code/Description</u>	<u>Charge</u>
_____	92015 Refraction (check for glasses prescription)	<u>\$ 40.00</u>

Patient Signature: _____ **Date:** _____