Patient Name:_____ DOB:_____

Routine Vision Policy

Routine vision services are not covered by Medicare and many other insurances. Reston Eye Associates (REA) does not participate with any vision plans. Routine services include routine eye check-ups as well as the following:

Refraction - $65 (92015): Process of determining the eye's refractive error and testing for best-corrected vision or need for corrective lenses (glasses or contacts). It is an essential part of an eye exam to evaluate if any further visual improvement can be achieved.

Contact Lens Fitting - $100-$200 (92310): Prescription and fitting of contact lenses. The contact lens prescription is not the same as a glasses prescription. The charge is variable depending on the type of lenses fitted and/or prescribed ($100 for spherical, $150 for toric, and $200 for multifocal lenses).

Contact Lens Rx - $50: Updating a contact lens prescription.

Payment for the above services is required at the time of the office visit for all patients with Medicare, Cigna, BCBS, as well as uninsured patients. (If BCBS reimburses this office for any of these rendered services, REA will send a refund check to the patient by mail.)

All other insurances will be billed for these charges and in the event the insurance considers this a non-covered service and denies payment, the patient will be responsible for the full payment and will be billed accordingly.

For anyone enrolled in a vision plan, there is a possibility the vision plan will reimburse the patient but not REA for these services. Please ask for a copy of the superbill and/or receipt if you plan to submit these charges yourself.

By signing below, I acknowledge that I have read and understand this notice and agree to its terms and conditions. I accept full financial responsibility for the cost of these services if rendered, in case of denial of payment by my insurance plan. I further understand that payment for these services may be due at the time of my visit, in addition to any copayments or deductibles due for the medical portion of the exam.

A signed copy of this form is available upon request.

Signature:_____ Date:_____