



RIVERSIDE EYE CENTER, P.C.

# Advanced Beneficiary Notice (ABN)

4050 River. Rd.  
East China, MI 48054

4656 24<sup>th</sup> Ave.  
Fort Gratiot, MI 48059

**Patient's Name** \_\_\_\_\_ **Date** \_\_\_\_\_

This form is to help you make an informed decision about receiving a refraction. A refraction is the part of the eye exam that determines your eyeglass prescription. Although this test is a very important part of your exam and is required for certain surgical procedures (such as cataracts), it is not considered a "medical procedure". Therefore most medical insurances, including Medicare and Medicaid will not cover the cost of the refraction.

If you have "optical insurance" it will cover the refraction fee. Ask the receptionist for more information.

The charge for this service is \$30.00. Indicate below if you would like this service.

   **I want to receive this service.** I understand that payment is due when service is rendered.

   **I have decided not to receive the service.**

**Patient's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

## Privacy Policy Statement

I have received a copy of the office's privacy policy. I have had an opportunity to review it and have had any questions answered. I also understand that by signing below, I gave Riverside Eye Center, P.C., and its staff permission to call regarding health care, insurance, or billing information, normal test results, and appointment dates. A message may be left with/on my answering machine, voice mail, sent by fax or left with a family member.

**Patient's signature** \_\_\_\_\_ **Date** \_\_\_\_\_

## One Time Authorization Agreement

Statement to permit payment of insurance benefits to providers, physicians, and patients.

I request that payment of authorized insurance benefits be made to Riverside Eye Center, P.C. for any services furnished to me by this provider. I authorize any holder of medical or other information about me to be released to my insurer and their agents. This includes any information needed to determine these benefits for related services. I permit a copy of the authorization to be used in place of the original

**Patient's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Please note:** Your health information will be kept confidential in our offices. If a claim is submitted to Medicare or private insurers, we must share some of your health related information with them. All insurers are required by law to keep your information confidential.

