

# PEDIATRIC YEARLY PATIENT UPDATE

Today's date: \_\_\_\_\_

Patient's name: \_\_\_\_\_

Address : \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

DOB \_\_\_\_\_ SS # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Home phone # ( ) \_\_\_\_\_

Guardian Work/Cell # ( ) \_\_\_\_\_

Guardian Work/Cell # ( ) \_\_\_\_\_

Insurance name: \_\_\_\_\_

Name of PRIMARY INSURED: \_\_\_\_\_

Primary Insured's DOB \_\_\_\_\_

Primary Insured's SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

ID # \_\_\_\_\_

Group # \_\_\_\_\_

Patient relation to Primary Insured : \_\_\_\_\_

Pediatrician Name: \_\_\_\_\_

Phone # \_\_\_\_\_

Guardian Signature: \_\_\_\_\_



**FLORIDA EYE**

*Microsurgical Institute, Inc.*

## REFRACTION POLICY

A refraction is a measurement of the lens power necessary to prescribe glasses or other corrective lenses. **Most medical insurance plans, including Medicare, do not cover routine refractions examinations** (when no medical eye problem is known or suspected). The Health Care Administration/Medicare allows that we charge separately for that portion of the examination, since it is not a covered service.

**If you have a separate vision plan that covers routine or annual eye examinations and/or glasses, please let us know.** Your vision plan may assist you with your eyecare needs that are not covered by your medical plan.

If you have any questions regarding Medicare and insurance policies and procedures, please do not hesitate to ask. We will do our best to assist you. Medicare will only pay for services that it determines to be "reasonable and necessary" under section 1862(a) (1) of the Medicare law. Refraction is not a Medicare covered procedure therefor will not be covered by Medicare.

### **PATIENT'S AGREEMENT**

**I have been notified by my doctor that an eye refraction is not a covered procedure and that Medicare likely to deny payment and I have agreed to be personally and fully responsible for the payment of \$25.00.**

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

We bill Medicare for our patients. Please read and sign the following statement so we may extend this courtesy to you.

I, \_\_\_\_\_ state that I have not knowingly signed over my Medicare benefits to any individual or organization. I understand that I am responsible for any charges incurred if I have not met my deductible or if I have signed my benefits over to another person or organization such as an HMO.

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

Witness \_\_\_\_\_

*1717 Woolbright Road • Boynton Beach, FL 33426*

*(561) 737-5500 • FAX (561) 737-7055*

*Fellow American College of Surgeons • Diplomate American Board of Ophthalmology*