Date: _____ Id:_____

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

Vision insurance companies do not pay for all of the portions of your exam. Portions of your exam may be billed to your medical insurance. In that event, you will have to pay the specialist co-pay and any balance that is not covered by your medical insurance or the amount that goes toward any deductible you may have.

You have _____ medical insurance with a _____ deductible that is MET / NOT MET. Today you will have a specialist copay of _____ for the medical portion of the exam, and we will mail a bill for any fees applied to your deductible or that insurance did not cover.

You have _____vision insurance with a _____ copay.

Listed below are procedures that may be necessary, however, may not be covered by your medical insurance:

fundus photos	color vision test	pachymetry
external ocular photos	visual field test	corneal topography
gonioscopy	OCT scan	VEP

What you need to do now:

- Read this form completely so that you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below and sign this form.

OPTIONS: Please initial ONE option. We cannot choose an option for you.

_____**Option 1**. I want all necessary procedures done and you may bill my medical insurance for procedures that are not a part of the routine eye exam. I understand that if my medical insurance doesn't pay, I am responsible for payment, but I can appeal to my medical insurance by following the directions on the EOB. If my medical insurance does pay, you will refund any payments I made to you, less co-pays or deductibles.

_____**Option 2**. I want all necessary procedures done, but do not bill my medical insurance. You may ask to be paid now as I am responsible for payment. I cannot appeal if my medical insurance is not billed.

_____**Option 3**. I want my exam billed to my vision insurance only.

_____I accept the $_____ fee for fundus/external photos.

Signing below means that you have received and understand this notice.

signature: _____ date: _____

Acknowledgement of Receipt

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, obtain payment for services, and to conduct healthcare operations involving our office. The Notice of Privacy Practices you have been given describes these uses and disclosures in detail. I acknowledge that I have received the Notice of Privacy Practices from Sound Vision Care, Inc.

signature: _____

date: _____

Insurance Signature

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to Sound Vision Care, Inc. on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the CMS-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

signature: _____

date: _____