

Patient's Name: _____

NOTICE OF EXCLUSION FROM MEDICAL INSURANCE BENEFITS

There are items and services for which insurance will not pay.

- Medical health insurance does **not** pay for all of your health care costs. Medical health insurance only pays for covered benefits. **Some items and services are not covered insurance benefits and insurance will not pay for them (see examples below)**. Many of these services will enhance the medical care you will receive, though.
- When you receive an item or service that is **not** a covered insurance benefit, **you are responsible** for payment in full at the time of service.

The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them yourself. **Before you make a decision, you should read this entire notice carefully.** Ask us to explain, if you don't understand why your insurance won't pay.

Ask us how much these items or services will cost you. (Estimated Cost: \$ _____)

Medical insurance will not pay for:

- Routine eye care (no disease or pathology on exam) or refraction (measurement of eye prescription)
- Premium intraocular lenses and post refractive care, refractive surgery (Lasik, PRK, ASA, CK, etc)
- Pre- and post-op examinations and testing associated with refractive surgery after defined period of time.
- Wavefront analysis or corneal topography measurements in the absence of corneal diseases.

Because of the following exclusions* from medical health insurance benefits:

- Routine eye care
- Cosmetic surgery
- Refractive surgery

Insurance considers refractive surgery performed to reduce the patient's dependence on eyeglasses or contact lenses to be cosmetic, and therefore excluded from coverage. Additional services associated with such surgery are also excluded.

**This is only a general summary of certain exclusions from insurance benefits. It is not a legal document. The official insurance program provisions are contained in relevant laws, regulations, and rulings.*

Beneficiary Agreement

The undersigned accepts full financial responsibility for the services not covered by their insurance as described above.

Date

Signature of patient or person acting on patient's behalf