FORT WORTH EYE
ASSOCIATES

PATIENT CONSENTS

PATIENT NAME: _____DATE:_____

WE CHARGE A $25.00 FEE FOR ALL NO SHOW APPOINTMENTS

REFRACTION SERVICE AND FEE
(Glasses Prescription)

One of the most important parts of your eye exam today is the refraction. That is the part of the exam by which we determine whether your vision can be helped by a new glasses prescription. It is also how we determine the best possible visual acuity and function of your eye, which is essential medical information. It is NOT a covered service by Medicare and many other insurance plans. These plans consider a refraction a "vision" service not a "medical" service. Unless your plan automatically covers the refraction charge, this $25.00 fee is in addition to any co-payment your plan may require.

I have read the above information and understand that the refraction is a non-covered service. I accept full responsibility for the cost of this service if it is determined a glasses prescription is needed. As a courtesy we will file your insurance carrier on your behalf. If it is not a covered benefit, we will drop the balance to patient responsibility.

CONSENT TO TREAT

I understand that Fort Worth Eye Associates may dilate my eyes for the purpose of a comprehensive ophthalmic exam. I understand that I have the right to decline the dilation; however, if I decline, I cannot expect to receive a complete and thorough exam as defined by the American Academy of Ophthalmology.

MEDICAL STUDENTS

I understand that occasionally medical students may **OBSERVE** and learn from my eye exam; however, they will not be involved in my treatment.

APPOINTMENT REMINDERS

I understand that Fort Worth Eye Associates will utilize postcards to notify me of missed or yearly appointments unless I state otherwise.

As your trusted healthcare provider, we respect the fact that you have the right to refuse any or all of the above listed services.

YOU HAVE THE RIGHT TO DECLINE ANY OR ALL OF THE ABOVE

Signature of Patient or Responsible Party: _____

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