



## ADVANCE BENEFICIARY NOTICE (ABN)

For All Patients With Insurance, Including Medicare

*The Purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Read this entire notice carefully, ask us to explain, if you don't understand why your insurance plan may not pay.*

**Billing** Our office bills your insurance, including Medicare, for your office visits, tests and materials. The insurance company then reviews all submitted claims and, if approved, reimburses the approved amount. A co-payment may be required from you as determined by your insurance plan. The insurance companies, including Medicare, require co-pays to be paid at time of service.

**Deductible** A yearly deductible applies to insurance plans, including Medicare. The deductible usually takes effect each January. If our office is the first to submit an insurance claim for you, the insurance plan, including Medicare, will notify us that you have not yet met your deductible for the year. The insurance plan, including Medicare will not pay for your allowable fees until the deductible is met. You are responsible for these charges.

**Refractions** Some insurance plans do not cover a refraction. Refractions are never covered by Medicare therefore you will be responsible for this charge.

**Glasses/Contact Lenses** There are numerous variations for glasses / contact lens benefits. Your insurance plan may offer: 1. a fixed dollar amount, 2. allow for balance billing, 3. a discount, or 4. require a co-pay

**Covered / Non-Covered** Services and materials are covered by insurance plans, including Medicare, when their guidelines are met. The fact that your insurance plan, including Medicare, may not pay for a particular item or service does not mean that you should not receive it. Your insurance plan, including Medicare, may deny payment based on their guidelines, and / or you may not have met your deductible. If payment is denied, then you shall be responsible for the charges.

**Consent to Treat** Consent for treatment for myself and/or on behalf of the Minor or Individual for which this information pertains. I give permission for the doctor to examine, consult, diagnose, and initiate treatment as deemed appropriate. I further attest that I am the Parent or Legal Guardian of the Minor or Individual and have the authority to authorize care and treatment.

**By signing below, I agree to each of the above statements for myself and/or on behalf of the Minor or Individual for which this information pertains. ANY outstanding balances owed to The Optometry Group, PLLC must be paid in full before being seen. ANY office credits will be automatically used on ANY outstanding balances. ANY balances past 90 days will automatically be turned over to collections. You will then be responsible for: outstanding balance, collection fees and/or legal fees.**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Staff Initial: \_\_\_\_\_ Account#: \_\_\_\_\_