**Advance Beneficiary Notice of Non-coverage (ABN)**

Medical and Vision insurance do not cover all services. These services may include the following:

| SERVICES OR TESTS | FEES | DESCRIPTION OF DIAGNOSTIC TEST |
|---|---|---|
| **Pupil Dilation** | **Included in exam fee**<br>_____ **Yes, I consent**<br>_____ **No, I decline**<br>**(PLEASE INTIAL)** | **WILL BE PERFORMED AS NECESSARY.** Eye drops are used to allow Dr. Ton to exam the retina for holes/tears/abnormalities. The side effects are light sensitivity and decreased ability to focus up close for 4-6 hours. |
| **Refraction** | **$60** (covered by vision plans) | Needed to determine your prescription for glasses.<br>**(MEDICAL INSURANCE DOES NOT COVER REFRACTION)** |
| **Pre-Test Bundle** | **$80 (savings of $30)**<br>_____ **Yes, I consent**<br>_____ **No, I decline**<br>**(PLEASE INTIAL)** | **iWellness Exam, Topography and Retinal Photos -**<br>Dr. Ton recommends these tests to be performed yearly.<br>**(NOT COVERED BY INSURANCE)** |
| **DESCRIPTION OF TESTS BELOW.<br>You can also choose to select individual testings and decline the Pre-Test Bundle.** | | |
| **iWellness Exam** | **$40** _____ **Yes, I consent**<br>_____ **No, I decline**<br>**(PLEASE INTIAL)** | **Recommended for all patients age 12 and older**: a quick, non-invasive light scan that allows us to see beneath the surface of your retina. This unique technology can help detect vision threatening diseases in their very early stages when they are most treatable. |
| **Topography** | **$30** _____ **Yes, I consent**<br>_____ **No, I decline**<br>**(PLEASE INTIAL)** | **Recommended for all patients age 12 and older:** a non-invasive technique for mapping the surface curvature of the cornea. The cornea is responsible for 70% of the eye's refractive power so the topography is important in determining the quality of vision and corneal health. |
| **Retinal Photos** | **$40** _____ **Yes, I consent**<br>_____ **No, I decline**<br>**(PLEASE INTIAL)** | **Recommended for patients age 5 and older:** photos of the retina, macula, blood vessels and optic nerve (dilation not necessary for most patients). |
| **CONTACT LENS SERVICES** | | |
| **Contact Lens Fitting/Evaluation**<br>Applies to all new/returning contact lens wearers. | **$75-$800**<br>___ **Yes, I consent**<br>___ **No, I decline**<br>**(PLEASE INTIAL)**<br>**Contact evaluation/fitting fee is a separate charge from an eye exam and is non-refundable.** | Dr. Ton recognizes that all eyes are different and require different care. Depending on your contact lens requirements, the following services will be provided: contact lens training, lens care kit, trials (if available), and follow up visits to finalize prescription. For patients who require additional correction or specialty lenses such as astigmatism, multifocal, irregular corneas, post surgical corneas or keratoconus, the office will provide a quote that matches each individual's needs. Once Dr. Ton has finalized your prescription, you are eligible to come back within 3 months to make changes without a follow up fee. |

**WHAT IS THE REASON FOR YOUR VISIT TODAY?** ☐ yearly exam ☐ new glasses ☐ blurry vision ☐ headaches ☐flashes of light

☐ dry eyes ☐contact lenses ☐ other: ____________________________________________

**ARE YOU INTERESTED IN:** ☐ computer glasses ☐ colored contact lenses ☐ prescription sunglasses ☐ Latisse® (longer lashes)

☐ Vuity™ (near focus) ☐ Upneeq® (eye lid lift)

**COMMUNICATION PREFERENCE:** ☐ Text OR ☐Telephone (_______) - _________-_________

☐ Email: ______________________________________________________________

**CURRENT ADDRESS:** ______________________________________________________

**PAYMENT POLICY: (CO) PAYMENTS FOR SERVICES AND MATERIALS ARE DUE AND PAYABLE AT TIME OF SERVICE.** The filing of a claim for any services rendered **DOES NOT GUARANTEE PAYMENT** from your insurance company. You will be financially responsible for unpaid services and materials. We must emphasize that, as a medical care provider, **our relationship is with you,** not your insurance company. Unaccompanied minors must make payment arrangements prior to the appointment. **(PLEASE INITIAL)** ______

**AUTHORIZATION TO RELEASE INFORMATION:** A copy may be used as an original. I hereby authorize the release of any medical information to my insurance carrier or to a licensed physician concerning my illness and treatment. I also request payment of my insurance benefits to Enhance Eye Care/Dr. Jocelyn Ton. **(PLEASE INITIAL)** ______

**HIPPA ACKNOWLEDGEMENT:** Our Privacy Practice is to not to release any of your information without your written consent.

Signing below means that you have received this notice and understand the charges. If you have any questions, please ask the staff to clarify any charges prior to services being rendered. Thank you!

| **Patient/Guardian Signature:** | **Date:** |
|---|---|
| **Patient Name:** | |