A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare/Medicaid doesn't pay for **D.**_____ below, you may have to pay. Medicare/Medicaid does not pay for everything, even some care that you or your health care provider have good reason to think you need.

D.	E. REASON MEDICARE/MEDICAID MAY NOT PAY	F. ESTIMATED COST
1 .REFRACTION	NOT MEDICALLY NECESSARY	$ 35.00
2. VISUAL FIELDS	NOT ELIGIBLE DUE TO FREQUENCY	$127.00
3. ANTERIOR SEGMENT	DEDUCTIBLE NOT MET	$130.00
4. POSTERIOR SEGMENT, OPTIC NERVE		$130.00
5. POSTERIOR SEGMENT, RETINA, MACULA		$130.00
6. EXTERNAL OCULAR PHOTOGRAPHY		$ 35.00
7. FUNDUS PHOTOGRAPHY INTERPRETATION		$109.00
8. OTHER		$

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**____ listed above. You may ask to be paid now, but I also want Medicare/Medicaid billed for an official decision on payment, which is sent to me on a Medicare/Medicaid Summary Notice (MSN). I understand that if Medicare/Medicaid doesn't pay, I am responsible for payment, but **I can appeal to Medicare/Medicaid** by following the directions on the MSN. If Medicare/Medicaid does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**____ listed above, but do not bill Medicare/Medicaid. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare/Medicaid is not billed.**

☐ **OPTION 3.** I don't want the **D.**____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare/Medicaid would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare/Medicaid decision.

Signing below means that you have received and understand this notice. You may also ask to receive a copy of this form.

I. SIGNATURE:	J. DATE:

HIPAA PRIVACY ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I understand that this office is HIPAA compliant and acknowledge that the HIPAA policies are posted and available to read, upon request.

Patient/Guardian signature:_____ Date:_____

Payment Policy:

I hereby assign all medical benefits, including all major medical benefits to which I am entitled including Medicare, Private insurance and any other health plans, to Primary Focus Eye Center. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure the payment. If my insurance company has not reimbursed Primary Focus Eye Center within 90 Days, I may be billed for any services or products that I have received. I understand that I am responsible for the balances due after billing. I understand that a late fee of $5.00 may be charged if I do not pay my balance within 30 days after receiving my statement. I certify that my responses on this form are accurate to the best of my knowledge. **I certify that I understand that there are no refunds or exchanges and that all sales are final unless covered under manufacturer warranty.**

Signatre:_____ Date:_____