Name: _____

DOB: _____

David A. Patton, O.D.
Bruce D. Gilliland, O.D.
Frank A. Carusone, O.D.

Pharmacy

IF the doctor needs to write you a prescription, we will send the Rx to your pharmacy electronically or call it in for you. We need your pharmacy preference.

Name of Pharmacy: _____ Address: _____

Phone: _____ Special Instructions: _____

Second Pharmacy: _____ Address: _____

Phone: _____ Special Instructions: _____

Advance Beneficiary Notice of Non-Coverage (ABN)

NOTE: If Medicare or your medical insurance does not pay for **certain procedures** listed below, you may have to pay. *Insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect that Medicare or insurance will not pay for the following:*

Services	Reason Insurance May Not Pay:	Estimated Cost
CPT code: 92015 Refraction (determines your eye glass or contact prescription)	**If your diagnosis is medical and your vision coverage doesn't cover your medical exam, your insurance may cover the exam but not the refraction. (considered routine vision)**	**$35.00**

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the procedure recommended by the doctor.
  Note: If you choose Option 1 or 2, we will help you to use any insurance that you have.

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

☐ **OPTION 1.** I want the procedure listed above **IF recommended by the doctor**. I may be asked to pay now, but I also want Medicare or my insurance billed for an official decision on payment, which is sent to me as an EOB (explanation of benefits). I understand that if insurance doesn't pay, I am responsible for payment. If money is collected and insurance **does** pay, a refund of any payments I made, less co-pays or deductibles, will be returned to me or left as a credit on my account.

☐ **OPTION 2.** I want the recommended procedure, but do not bill my insurance. I will pay now as I am responsible for payment. **I cannot appeal if Medicare or my insurance is not billed**.

☐ **OPTION 3.** I **DON'T** want the procedure if recommended or ordered by the doctor. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if my insurance would pay.**

This notice gives our opinion, not an official insurance decision. If you have other questions on this notice or about insurance billing, please ask one of trained staff members or the administrator.
Signing below means that you have received and understand this notice. You may also request a copy.

Signature:	Date: