Surgical Eye Care, P.A.

Alan W. Brown, M.D.
Richard Dax Hawkins, M.D.

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

The purpose of this form is to help you make an informed choice about whether or not you want to receive these services, knowing that you might have to pay for them yourself. Ask us any questions that you may have after you finish reading. **We anticipate that your insurance will not pay for the services that are listed below.** Insurances, such as Medicare, **do not** pay for all your medical costs and only pay for covered services when rules are met. The fact that your insurance may not pay for a particular service does not mean you should not receive it. There may be a valid reason your doctor recommended the service.
Presently, your insurance may not cover Corneal Topography and Refraction services.

1. **Corneal Topography ……$60.00**

Corneal Topography measures the shape of the eye to determine the location and amount of astigmatism present. This information is very important to accurately calculate the lens implant power and decide on your surgical options.

2. **Refraction ……..$40.00**

Refraction is completed to measure the prescription of the eye. This information is used in the calculation of the implant power used in the cataract surgery.

PLEASE CHOOSE ONE OPTION

☐ Option #1 **YES,** I want to receive these services.
I understand that insurance will not decide whether to pay unless I receive this service. Please submit my claim to insurance. I understand that I will pay my bill while my insurance is making its decision. If insurance does pay, I will be refunded any payments I made that are due to me. If insurance denies payment, I agree to be personally and fully responsible for payment. I understand that I will pay out of pocket the amount due. I understand I can appeal my insurance decision.

☐ Option #2 **NO,** I do not want to receive these services.
I will not receive these services. I understand that not receiving these services may limit the ability of the doctor to provide an accurate diagnosis of my condition, or may prevent an accurate visual outcome should I need vision restoration surgery.

Print Name: _____ Date: _____

Signature: _____ Date: _____

PLEASE CONTINUE THIS FORM ON THE BACK →

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