WANDA PAK, M.D., P.C.

Ophthalmology, Ophthalmic Surgery, Laser Refractive Surgery

Routine Eye Examination

Most medical insurance plans, including Medicare, do not cover routine eye examinations. This office does not submit routine eye examinations for insurance reimbursement without prior authorization.

Refraction Policy

A refraction is the measurement of the lens power necessary to prescribe or change your glasses or contact lenses. Most insurance plans, including Medicare, do not cover refraction. If your examination includes a refraction, there is a $60.00 fee since it is not a covered service.

Contact Lens Policy

A contact lens examination must be performed yearly before a new contact lens prescription can be issued. Most insurance plans, including Medicare, do not cover a new contact lens evaluation or yearly examination. If your examination includes a new contact lens evaluation or yearly examination, there is a fee since it is not a covered service.

Missed Appointment Policy

This office charges for missed appointments. Failure to provide 24 hours notice of cancellation of an appointment will result in a $25.00 charge.

Financial Responsibility Agreement

I hereby authorize this office to apply for benefits on my behalf for services rendered. I understand that my insurance is an agreement between the insurance provider and myself, not between the insurance provider and this medical office. If authorization is required from my primary care physician, I have obtained such documentation prior to this visit.

I therefore request payment from my insurance company to be made to Wanda Pak, M.D., P.C. I also understand and agree that, regardless of my insurance status, I am responsible for the balance of my account for any medical services rendered on the date of service.

I certify that the information I have reported with regard to my insurance coverage is correct. I authorize the release of any necessary information, including medical records, to determine insurance benefits to which I may be entitled.

_____	_____	_____
Patient/Parent or Guardian Signature	**Print Name**	**Date**
_____		_____
Physician's Representative Signature		**Date**

PLEASE GIVE THE RECEPTIONIST YOUR INSURANCE CARD FOR PHOTOCOPYING AFTER COMPLETING THIS FORM