SouthEast Eye Physicians & Surgeons
Raffi Karapetian, D.O.
Matthew Littel, O.D.

FINANCIAL STATEMENT
Patient's or Authorized Person's Signature

I, the undersigned, give my authorization to treat and assign directly to Southeast Eye, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submission. I understand that payment is expected at the time of service. I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

Patient Name (Printed): _____

Signature **X** _____ Signature Date _____

REFRACTION SERVICES AND FEES

A refraction is the process of determining your best corrected vision and if there is a need for corrective eyeglasses or contact lenses. A refraction is typically not a covered service by Medicare or most medical insurance plans. These plans consider a refraction a "vision" service not a "medical" service. If you request a glasses prescription at your visit, our office fee for a refraction is $30.00 and this fee is collected at the time of service in addition to any co-payment your plan may require. Should your plan pay us for the refraction, we will reimburse you accordingly.

Refraction

CPT Code: 92015

Fee: $30.00 USD

Patient Name (Printed): _____

Signature **X** _____ Signature Date: _____

_____ _____ _____

Guardian Signature (Legally responsible applicable) **Relationship to patient** **Staff Witness**