Columbia Basin Eye Clinic, P.S.

1022 West Ivy Avenue * Moses Lake, WA 98837 * 509-765-7845

Dilation and Refraction Fees

Patient Acknowledgement Regarding Precautions Following Dilation

It may be necessary to dilate your eyes during the course of your eye examination or treatment. Dilation results in sensitivity to light and an inability to see well at close range or distance for a few hours. We provide free disposable sunglasses or dark sunglass inserts. Patients should wear sunglasses, be cautious walking and going up or down stairs. We recommend avoiding driving or operating dangerous machinery immediately afterwards. We recommend that someone accompany you to drive you home or that you wait until your eyes return to normal so that you can drive safely.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize Columbia Basin Eye Clinic, PS and/or such assistants as may be designated by Dr. Roth/Dr. Huber/Dr. Thomas to administer dilating eye drops. The eye drops are necessary to diagnose my condition and evaluate the health of my eyes.

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Patient's Signature (Legally Responsible Adult for minor)	**Date**	**Staff Witness**

Refraction and Contact lens Service and Fee

- ✓ A refraction is the process of determining your best corrected vision and if there is a need for corrective eyeglasses or contact lenses. It is an essential part of an eye examination and is necessary to write a prescription for glasses or contact lenses.
- ✓ A refraction is ***NOT*** a covered service by Medicare or most insurance plans. These plans consider a refraction a "vision" service not a "medical" service.
- ✓ We will ***NOT*** file the charge for a refraction with a health insurance plan unless we know that your plan covers the refraction charge.
- ✓ If you have questions whether your insurance covers refractions, please call your insurance provider.
- ✓ Our fee for a refraction are $100 for glasses and $30 for contact lens. This fee is collected at the time of service in **addition to any copayment your plan may require**.

I have read and understand the above information. I accept full financial responsibility for the cost of a refraction, if provided, and understand **payment is due at time of service**. I understand that any copayment, coinsurance or deductible I may have are separate from and not included in the refraction fee.

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Patient's Name (Printed)	**Date**	**Relationship to Patient**

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Patient's Signature (Legally Responsible Adult for minor)	**Staff Witness**