Non Covered Services

Refraction and Contact Lens Services at Pamel Vision and Laser Group are not covered by insurance. The fees for the services listed below are due at the time of the visit.

Refraction Services:

Your examination today may also include a non-covered fee of $75.00 for refraction services (measuring current eyeglasses, testing of vision, and determining an eyeglass prescription). **Without refraction, current eyeglasses cannot be fully evaluated, updated glasses cannot be prescribed, and visual/optical changes of the eye cannot be assessed. If you experience any problems with new eyeglasses please come back within 30 days and we will gladly recheck your prescription.**

I understand and consent to have refraction, and I am aware of the $75.00 fee. I have been advised in advance and understand that my medical insurance does not cover this service. I understand that there is an additional fee as outlined above and that this fee is due at the time of service.

Patient name (Please Print):	
Signature:	
Date:	
Accept :	Decline:

Contact Lens Assessment:

A separate fee of $75.00 will be charged if contact lenses are worn and need to be assessed. A contact lens assessment (examining the health of your eyes in the presence of a contact lens, determining if power and fit of the lens(es)are adequate) is necessary to renew the prescription for current contact lens wearing patients. **Without a contact lens assessment, ocular health/visual/optical changes cannot be fully evaluated, current contact lenses cannot be assessed, and updated contact lenses cannot be prescribed.** All contact lenses are medical devices and should only be worn as prescribed. If you are unable to provide the current contact lens prescription, not wearing the current contact lens(es), or a modification of the lens is necessary due to vision, comfort, or ocular health; a separate contact lens new fit or refit fee will be assessed.

I understand and consent to have a contact lens assessment, and I am aware of the $75.00 fee. I have been advised in advance and understand that my medical insurance does not cover the contact lens assessment, contact lens fitting fees, or the fee for the lenses themselves. I understand that there is an additional fee as outlined above and that this fee is due at the time of service.

Patient name (Please Print):	
Signature:	
Date:	
Accept :	Decline: