



**NORTHERN NEW JERSEY  
EYE INSTITUTE**

**Ophthalmologists**

Charles J. Crane, MD  
*Cataract, Eye Plastic Surgery,  
Refractive Surgery,  
Medical Retina & Glaucoma*

Bernard C. Spier, MD  
*Cataract, Refractive Surgery,  
Medical Retina & Glaucoma*

William S. Bloom, MD, PhD  
*Medical Ophthalmology*

**Optometrists**

Maureen C. Considine, OD

Bruce A. Goldstein, OD

Christine L. Fitzpatrick, OD

Arthur L. Siegel, OD  
*Low Vision Services*

In-Ae "Grace" Choi, OD

**Practice Administrator**  
Shirley Vitale, CRCST, LPN

**REFRACTION SERVICE AND FEE**

A refraction is the process of determining if there is a need for corrective eyeglasses or contact lenses. It is an essential part of an eye examination and necessary to write a prescription for glasses or contact lenses.

**Most medical insurance plans, including Medicare, do NOT cover routine refractions or routine eye examinations** (when no medical eye problem is known or suspected). Medicare allows that we charge separately for that portion of the examination, since it is not a covered service.

If you have a separate **vision plan** that covers routine or annual eye examinations and/or glasses, please let us know. Your vision plan may assist you with your eye care needs that are not covered by your medical plan.

Our office fee for a refraction is \$45 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.

If you have any questions regarding Medicare and insurance policies and procedures, please do not hesitate to ask. We will do our best to assist you.

**Patient Acknowledgement**

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service and understand it is due at time of service. I understand that any co-payment, coinsurance, or deductible I may have are separate from and not included in the refraction fee.

\_\_\_\_\_  
Patient Signature (Parent for Minor)

\_\_\_\_\_  
Date