ViewPointe Vision
304 N 179th Street Suite 203
Omaha, NE 68118
402-614-4322

Patient's name (print):_____

ADVANCE BENEFICIARY NOTICE

NOTE: You need to make a choice about receiving these health care services:

Your insurance may or may not pay for the services listed below. It may be a covered service and applied to your deductible/copay, or it may be considered a non-covered service. The fact that your insurance may not pay for this particular service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, your insurance may not pay for:

Service: Comprehensive Eye Exam & Refraction

The purpose of this form is to help you make an informed choice about whether or not you want to receive these services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully.

- Ask us to explain if you don't understand why your insurance may not pay.
- Ask us how much these services will cost you (est. cost $250-285) in case you have to pay for them yourself.

PLEASE CHOOSE ONE OPTION. CHECK ONE LINE. SIGN & DATE.

_X_ **Option 1. YES. I want to receive these services.** I understand that these services will be submitted to my insurance company for payment, but that they may be denied or applied to my deductible. If my insurance denies payment or applies these services to my deductible, I agree to be personally and fully responsible for payment.

___ **Option 2. No. I have decided not to receive these services.**

_____ _____

Date Patient Signature