Your Practice Name
Address
City, State ZIP
Phone Number

VISION SCREENING

Patient Name: _____

Every child needs a periodic vision examination, which something we provide here in our office. **Your insurance company might pay** part of the fee for an ophthalmologist or optometrist to check your child's eyesight, but you will likely have a co-payment. **Insurance Companies often will not** pay us for the vision screen but you have already paid your co-payment.

We care for you and your children, but just like the ophthalmologist and optometrist, we have expenses and cannot provide this service for free. We will provide this service for our standard fee or you may take your child to an optometrist or ophthalmologist instead. Our fee of $X0.00 compares to an average Optometrist fee of $X+0.00 or even an Ophthalmologist fee of $X+++ to $X++++ per visit. Even if you are covered, you will probably have a co-payment.

We are more convenient as you are already here and we do a good job but, we respect and support your choice. ***Please understand that if we provide this service and your insurance carrier elects not to pay us then you will be held responsible for the standard fee listed above.*** Please select from the following choices:

_____ Please check my child's vision at today's visit. I understand I am responsible for the $30.00 fee if by chance my insurance carrier does not cover this service.

_____ I do not wish for my child's vision to be checked at today's visit. I will take my child to an Ophthalmologist or Optometrist soon.

Parent Signature: _____ Date: _____