HARMAN EYE CENTER
An AVP Company

MEDICARE CHECKLIST AND FACTS

PATIENT:	DOB:

1. **DO YOU HAVE ANY OF THE FOLLOWING? PLEASE CIRCLE ALL THAT APPLY:**

Problems with Glare	Change in vision	Dry eyes	Red eyes
Glasses don't work well	Problems driving at night	Watery Eyes	Itchy eyes
Glasses don't fit well	"Laugh lines"	"Crows Feet"	Droopy eyelids

2. **DO YOU HAVE DIFFICULTY, EVEN WITH GLASSES, WITH ANY OF THE FOLLOWING? CIRCLE ANY THAT APPLY:**

Writing checks or filling out forms	Reading small print such as labels on medical bottles
Reading a newspaper or book	Recognizing people when they're close to you
Watching Television	Reading traffic, street, or store signs
Seeing steps, stairs or curbs	Seeing a golf or tennis ball
Playing games such as bingo	Doing handwork like sewing or carpentry

3. **ARE YOU CURRENTLY TAKING ANY OF THESE MEDICATIONS?**

FLOMAX (TAMSULOSIN) - PLAQUENIL (HYDROXYCHLOROQUINE) - TOPAMAX (TOPIRIMATE) - GILENYA (FINGOLIMOD)

Medicare Payment Guidelines

Our primary concern is to provide you with the best care possible. The following information will explain Medicare's rules for paying and help you understand what to expect out of pocket. Your Medicare Part B coverage is what will cover your bills in office for surgeries, diagnostic tests, and office visits. All our locations are participating providers with Medicare therefore you will receive a savings for your services.

* For 2024 Medicare has applied a **$240.00 deductible** to be met before Medicare will begin covering their portion of covered services. As a company policy our locations require patients to pay the applicable amount towards their Medicare deductible at time of service.

* After your deductible is met Medicare pays **80%** of the guideline amount for covered services. The other **20%** is applied to your out of pocket and billed to you or your supplemental insurance if you have one.

* All participating doctors are required by Medicare to collect any patient responsibility left after Medicare and your supplemental insurance processes your bill. This may include payment for your visits due at time of service.

Non-covered Service by Medicare (will be patient responsibility)

Your out-of-pocket 2024 deductible: $240.00 - **Refraction:** $45.00 – **DMV Visual Field:** $105.00 – **20% co-insurance**

Forms Fee: (all forms/paperwork the office fills out at the patient's request) $25.00

Eyeglasses: Costs may vary **Contact lenses:** Costs may vary

By signing below, you acknowledge that you have received and understand the above.

SIGNATURE: _____ DATE: _____