



MEDICARE CHECKLIST AND FACTS

PATIENT: _____ DOB: _____

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

- Itchy Eyes, Difficulty reading small print, Problems with glares, Dry Eyes, Double Vision, Watery Eyes, Floaters, Flashes of light, Swollen eye lids, Difficulty driving at night, Red Eyes, Headaches, Eye Pain, Change in vision, Eye Strain, 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 (TOPIRAMATE) - 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 2025 Medicare has applied a \$257.00 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 patient responsibility or if you have supplemental insurance, it may pick up the co-insurance.

* 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 2025 deductible: \$257.00 – 20% co-insurance – Refraction: \$48.00 – DMV Visual Field: \$105.00

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

Eyeglasses: Costs may vary Contact Lens Fit Fees: Cost may vary Contact lenses (material): Costs may vary

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

SIGNATURE: _____ DATE: _____