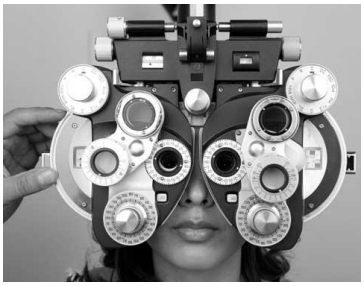
SCOTTSDALE
EYE PHYSICIANS & SURGEONS, PC

Refraction Test Responsibility Agreement

Refraction Test:

- If you are here for a **Comprehensive Eye Exam, you will need a Refraction** to determine how well the eyes can see.
- If you desire a new or updated **glasses or contact lenses prescription, you will need a Refraction test.**
- If your **vision has decreased** (whether observed by you or found during your examination) **you will need a Refraction test**.
- The Refraction test helps the doctor tell if reduced vision is due to incorrect glasses or something medically related.
- Unless you have vision insurance or your medical insurance specifically covers this test, you are responsible for the **$72** charge for the Refraction test.
- Our doctors strongly recommend you get this test.



☐ **YES!** I would like the Refraction test (**$72)**
☐ **No.** I decline the Refraction test

iScription Refraction Test by Zeiss:

- The iScription Refraction test is a separate more precise automated refraction test.
- The iScription Refraction test can also be used to make high-definition digital iScription lenses for your glasses. **iScription lenses provide improved night vision, better definition of color and contrast, and improved visual comfort**. Please ask our optician for more details.
- Our office is one of the few practices in Arizona that offers iScription advanced technology.
- iScription lenses are premium lenses that are more expensive than traditional lenses. The charge for the iScription Refraction test is an additional **$30** over the regular Refraction test charge.
- Payment of the iScription test fee is the responsibility of the patient as the test is not covered by insurance companies.
- iScription lenses are only available in progressive or single vision styles. They are not available in bifocal or trifocal styles.

☐ YES! I would like to add the iScription to my Refraction test (additional $30)
☐ No. I decline the iScription Refraction test.

I hereby affix my signature as an acknowledgement I have read the above and understand my financial responsibility.

Patient or Guardian Signature: _____

Patient Name (Printed): _____

Date: _____