



PLEASE READ AND SIGN ONLY IF YOU HAVE MEDICARE

FOR MEDICARE PATIENTS ONLY

Certain services provided in our practice are considered “**non-covered services**” by Medicare. The patient is responsible for any non-covered services and is expected to pay for these services today. One such service is called a refraction and is performed to measure if one’s vision is capable of being improved through the use of lenses. The charge for this service is \$35.00. We are required to inform you about the non-covered services. Please sign below to acknowledge that you have been informed of these services and charges.

Signature: _____ **Date:** _____

MEDICARE ONE TIME AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to **Donald J. Digby, MD, PA** for any services furnished by that physician. I authorize any holder of medical information about me to release to the **Health Care Financing Administration** and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature: _____ **Date:** _____

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The North Carolina Medicaid Program requires us to inform you before you are seen by Dr. Digby that this office **does not** make eyeglasses. Dr. Digby will give you a prescription for glasses that you may take to an optical shop that accepts Medicaid. You have the right to see another physician who may be able to provide both your eye exam and make your eyeglasses.

I understand the information above and I want to have my eye exam with Dr. Digby. I understand that I will need to have eyeglasses made elsewhere.

Signature: _____ **Date:** _____