Ozer Family Vision Care
2316 Meetinghouse Road
Boothwyn, PA 19061
610-485-1500

Medicare Beneficiary Statement

I hereby acknowledge that I have been informed that Medicare will not pay for "non-covered" services or materials and that I am personally responsible for payment. I understand the following:

1. Medicare will not pay for the refraction portion of my examination (the portion where the doctor asks: "Is it better one or two?"), the 20% deductible on covered portion of the examination or my annual deductible. (If you have not yet paid your deductible see the next line)

   ______ (Initial) I elect to pay my deductible now

2. (For post cataract surgery patients only) The extra charge for the deluxe frame I have chosen, which is not covered by Medicare, is my responsibility. I understand that standard frames are available at no extra cost.

   DATE OF CATARACT SURGERY ___________ SURGEON_______________

3. I understand Medicare will not pay for contact lenses, spectacle lenses, or frames unless I have had cataract surgery.

4. I am responsible for payment for any professional services and/or materials which are not covered under the Medicare program.

I request that payment of authorized Medicare benefits be made on my behalf of George E. Ozer for any services furnished to me by this provider and authorize release of any medical information about me to the Health Care Financing Administration and its agents necessary to determine these benefits or the benefits payable for related services.

Name (printed):____ Date: _______________

Signature: ___________________________________ Medicare #: ____________________