DOCS

Dedham Ophthalmic Consultants and Surgeons

ADVANCE BENEFICIARY NOTICE (ABN)

Patient's Name: _____

The purpose of this form is to help you make an informed choice about your visit today. Before you make a decision about your options, you should **read this entire notice carefully.**

Items of Service

LipiView - Evaluation of Tear Film with Interferometry CPT 0330T

LipiFlow - Treatment of MGD with Heat/Intermittent Pressure CPT 0207T

Medical and/or Vision Insurance plans do not cover the LipiView or LipiFlow services.

You will be responsible for the 100% of all fees for each procedure _____ (initials)

The following items are NOT covered by any insurance. You are responsible for these charges:

Items or Services:	**Cost:**
☐ LipiView	$ included w/treatment
☐ LipiFlow Right Eye	$ _____
☐ LipiFlow Left Eye	$ _____

I have read and understand the above statement and agree to pay for all services, and understand that my insurance will not be billed for the procedures listed above.

Signature_____Date_____