



Orchard Pediatrics, P.C.

Newborn through Adolescent Care

Patient's Name: _____

Insurance Co: _____

Advance Beneficiary Notice (ABN)

PHOTOSCREENING

Your doctor has recommended photoscreening because it is a rapid and highly reliable technique for the early detection of sight-threatening conditions in children such as refractive errors (nearsightedness, farsightedness, astigmatism), amblyopia (lazy eye), strabismus (crossed eyes), and media opacities (cataracts). It can detect these conditions earlier, easier, and more accurately than other methods of vision screening in young children.

In no way does it replace a complete and comprehensive eye examination by an optometrist or ophthalmologist, nor can it be expected to detect all eye diseases or conditions that affect vision.

You need to make a choice about photoscreening for your child.

Some aspects of health care are covered by your health care service plan, however some other aspects are not covered benefits and consequently your health plan will not pay for them. When you receive an item or service that is not a covered benefit, you are responsible to pay for it.

PLEASE CHOOSE ONE OPTION:

- Option 1. YES. I want to have photoscreening performed on my child.**
- Option 2. NO. I have decided not to receive this service.**

You are responsible for the usual co-payments and deductibles that are associated with covered services. You are also responsible for all of the fees associated with noncovered items and services.

The extra charge for the photoscreening is \$35.00.

By signing below you agree to take financial responsibility for the cost of the item(s) or service(s).

Responsible party signature: _____

Date: _____