TOWER CLOCK
EYE CENTER

The difference is in sight.

PROFESSIONAL SOLUTIONS FOR CATARACTS, GLAUCOMA & CORNEA

Your insurance company **will** be billed from **THREE SEPARATE ENTITIES** for your cataract surgery as follows:

Tower Clock **Eye** Center (Clinic)	Surgeon's fee
Tower Clock **Surgery** Center (Facility)	Facility fee
NAPS (Nurse Anesthesia Professional Services) Please contact NAPS at 1-866-313-0337 for all billing questions related to anesthesia/sedation.	Sedation/Anesthesia

_____ **You will be responsible for paying any deductible, copay, and/or coinsurance that your insurance company deems as patient responsibility**.
Initial

Please contact your insurance company **before** surgery to find out what your possible responsibility will be for the above submitted charges. Also find out if a prior authorization is required for your procedure. If so, please contact our office so the prior authorization can be obtained. When contacting your insurance, use **cataract surgery CPT code 66984 with diagnosis H25.13**.

If you elect to have a **premium lens** or **Astigmatism Management Package** (for astigmatism reduction), you will have additional charges to the ones listed above. These are **not** submitted to insurance as they are considered **refractive surgeries** and therefore not covered.

_____ Astigmatism Management Package to treat astigmatism using incisions created by the LenSx® laser and/or a Toric intraocular lens implant at $1,500 **per eye.**

_____ Multifocal Lens Implant combined with Astigmatism Management Package to treat astigmatism using incisions created by the LenSx® laser at $3,100 **per eye.**
A Multifocal lens is designed to reduce the need for glasses and/or contacts after surgery.

_____ **I understand that inspite of the above technology. I still may need or choose to wear glasses/contacts after surgery.**
Initial

All fees for the above options are collected in full one week prior to your scheduled procedure.

I acknowledge understanding of all out-of-pocket charges/expenses as explained to me. I will be responsible for any charges/expenses not covered by my insurance company.

_____ _____

Patient Signature Date