(Customize top of form with name, address & phone) *(Provide 1 copy to patient; keep original in your files.)*

Patient's Name:

NOTICE OF EXCLUSION FROM HEALTH PLAN BENEFITS

You need to make a choice about having photobiomodulation of the retina for one or both eyes. This service is not a covered benefit and consequently your health plan will not pay for it. When you receive a service that is not a covered benefit, you are financially responsible for it.

The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully. ***Ask us to explain, if you don't understand why your health care service plan won't pay.***

Your doctor has recommended non-invasive photobiomodulation (PBM) of the retina as a treatment for early- or intermediate-stage dry age-related macular degeneration in one or both eyes. At the present time, there are limited treatment options for this disease. While dietary supplements, such as AREDS vitamins, may help slow the progression of AMD, they do not improve vision. Studies showed an average gain of 5.4 letters and a favorable safety profile with PBM.

You are responsible for the fees associated with a non-covered service. The charge for the physician's professional fee is $_____ for one eye and $_____ for two eyes on the same day. One series of PBM consists of 9 treatment sessions. One year of PBM consists of 27 treatment sessions.

Beneficiary Agreement
Accordingly, the undersigned accepts full financial responsibility for the non-covered services described above. If your health plan unexpectedly covers and pays for this procedure, your money will be refunded less any applicable deductible and copayment. _____ _____ Signature of patient or person acting on patient's behalf Date