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123 W. Washington Avenue
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Patients Using Insurance Benefits

I understand that it is not the responsibility of this office to know my insurance coverage. I am ultimately responsible for the payment of my medical bill in the event I have not met my deductible for the year, do not have routine vision coverage, this office or physician does not participate with my plan or I exceed the allowances of my insurance coverage. I understand that all co-pays, deductibles, contact lens service fees and Optomap retinal exam, not covered by most insurance, are to be paid in full today. I understand that my information will be released to third party insurers/payers and I may receive a bill for the portion of the services not paid by my insurance plan.

Patient Name: _____ Date of birth___/___/___

Signature of patient or guardian if under age 18_____ Date___/___/___

Patients Not Using Insurance Benefits

I understand that this office does not participate with my insurance, I am choosing not to use my insurance benefits or I do not have insurance benefits. I am aware that I am responsible to pay for all medical expenses. This includes the cost of the eye exam, contact lens services, pretesting including the Optomap retinal exam, contact lens services, glasses and contact lenses ordered.

I attest that I do not have Medicaid or other federally funded community health plan, as federal law prohibits Medicaid or federally funded community health plan recipients from paying out of pocket for these services.

Patient Name:_____ Date of birth___/___/___

Signature of parent or guardian if under age 18_____ Date____/___/___