

Waiver of Insurance Liability

Insurance Company _____

Insurance Member Name (if different than patient) _____

Member SS# _____ Date of Birth _____

Member Address _____

I acknowledge that the insurance information I have provided is the insurance for which I am currently eligible. I understand that I may be responsible for payment in full for all visits/procedures if not covered by insurance or if this information is incorrect.

I authorize Center for Sight to furnish information concerning my illness or medical treatment to the insurance carrier listed below, and hereby assign to the provider all insurance payments for medical services rendered to myself. I also acknowledge responsibility for payment of all medical fees regardless of any insurance I may have to assist me in this responsibility.

I understand that there will be a \$25.00 handling fee assessed for any and all checks returned due to non-sufficient funds or account closure. In the event a collection agency is required to obtain funds, I will be responsible for all collection fees up to and including attorney costs.

Patient/Guarantor Signature: _____ Date: _____

Refraction Service and Fee

Refraction is the process of determining if there is a need for corrective eyeglasses or contacts lenses. It is an essential part of an eye examination and necessary to write a prescription for glasses or contact lenses.

Most medical insurance plans, including Medicare, do NOT cover routine Refractions or routine eye examinations (when no medical eye problem is known or suspected). Medicare allows that we charge separately for that portion of the examination, since it is not a covered service.

Our office fee for a Refraction is \$40, which will be the responsibility of the patient if your medical insurance does not cover the service.

If you have any questions regarding Medicare and insurance policies and procedures, please do not hesitate to ask. We will do our best to assist you.

Patient Acknowledgement: I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service. I understand that any co-payment, coinsurance, or deductible I may have is separate from and not included in the refraction fee.

Patient Signature (Parent for minor)

Date