DEAR PATIENT:

We ask that you please read and sign this form as it concerns you, the patient.
Due to the many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible; therefore, we urge you, the patient, to please check with your insurance company regarding your coverage. It is your responsibility to know your individual coverage and its limitations. Failure to comply with this suggestion could result in you, the patient, being responsible for all costs incurred. Please remember that your insurance policy is between you and your insurance company. Medicare and most medical insurance do not cover routine eye exams and conventional contact lens fittings. On the other hand, vision care plans cover only routine eye exams. The doctors may recommend additional testing for medical conditions such as (glaucoma, cataracts, diabetes, etc.). These procedures may be covered under major medical insurance or Medicare. If you have a co-payment or out-of-pocket expense, deductible, etc., it must be paid at the time of service. You are fully responsible for payment or services rendered. Please call your insurance company and learn about your coverage. It may save you a lot of confusion and out-of-pocket expenses.

_____ _____ ___/___/____

Patient or guardian Print name Date