

Waiver of Insurance Liability

Insurance Company: _____

Insurance Member Name _____
(If different than patient) Last First Middle Initial

Relationship to the 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 will 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 above 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. I also understand that I will be assessed a late fee of \$5.00 per month on any outstanding balance unless other arrangements have been made.

Patient/Guarantor Signature: _____ Date: _____

Fees for Refractions, Contact Lens Evaluations and Contact Lens Fittings

Refraction is the process of determining if there is a need for corrective eyeglasses or contact lenses. It is an essential part of an eye examination and necessary to write a prescription for glasses or contact lenses. A Contact Lens Evaluation or Fitting is an examination of the curvature of your eye and is necessary to establish the best power, type and fit of a contact lens for the patient.

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 the Refraction portion of the examination, since it is not a covered service. Contact Lens Evaluations and Contact Lens Fittings are not covered services by Medicare or commercial insurance companies.

Our office fee for Refractions is \$40 and our fees for Contact Lens Evaluations and Fittings will vary according to the type of diagnosis and/or contact lens needed.

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 if 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/Guarantor of minor)

Date