INSURANCE POLICY

PERMISSION TO KEEP INSURANCE SIGNATURE ON FILE

I certify that the information given by me in applying for insurance payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance benefits, and I authorize payment of these benefits directly to Cox Eye Care on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the insurance company and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage, my signature authorizes the release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

I ALSO UNDERSTAND THE FOLLOWING REGARDING MY INSURANCE:

- Due to time constraints, we are unable to investigate which insurance company you have.
- If you are using insurance, you must notify our staff and present **ALL** of your insurance cards before services are rendered. If you have forgotten your card, we will assist you in rescheduling your appointment to another day. Due to different procedures for processing accounts, we cannot change the form of payment to insurance at a later date.
- Your health insurance is a contract between you and your insurance company. Knowing your benefits is **YOUR** responsibility. Any questions or complaints regarding your coverage should be directed to your insurance company.
- As a courtesy, we will do our best to provide you with accurate quotes for your portion of the bill. The quotes we provide come directly from your insurance company. However, your insurance company states they will not guarantee paying the quoted amount until they personally process your claim. In the event that we receive more payment than expected, you will be refunded. If there remains a balance due, you will be responsible for the additional charges.
- Payment is due when services are rendered and/or materials are ordered, including copays, deductibles, and services or materials not covered by insurance.

I ACKNOWLEDGE THAT I HAVE RECEIVED AND AGREE TO THE ***INSURANCE POLICY*** FROM COX EYE CARE.

PATIENT'S FULL NAME: _____ BIRTH DATE:_____/_____/_____

SIGNATURE: _____ RELATIONSHIP TO PATIENT:_____

(IF UNDER 18, MUST BE LEGAL PARENT OR GUARDIAN)

DATE:_____/_____/_____