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:

- 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.
- Insurance cards must be presented before services are rendered. If you have forgotten your card, we will be happy to assist you in rescheduling your appointment to another day.
- Due to time constraints, we are unable to investigate which insurance company you have.
- Due to different procedures for processing accounts, we cannot change the form of payment to insurance at a later date. If you are using insurance, you must notify our staff at the time of the service and present all of your insurance cards that day.

PATIENT'S FULL NAME: ______________________ BIRTH DATE: ____/____/____

SIGNATURE: ______________________ RELATIONSHIP TO PATIENT: __________

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

(IF UNDER 18, M,UST BE LEGAL PARENT OR GUARDIAN)

DATE: ____/____/____