South East Eye Family Vision Center

Medical Information and Payment Authorization

I request that payment of authorized medical benefits be made on my behalf to South East Eye Health Center, Inc., for services rendered. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, or any other insurer, any information needed to determine these benefits payable for related services. A copy or system generated printout of this release will be as valid as the original form. Although I have indicated that I am covered by the above health insurer(s), I acknowledge and agree that I am personally responsible for any co-payments and/or deductibles associated with the services I receive which are not covered by my insurance, and that I will be personally liable for all charges associated with the services I receive if for any reason it is determined that my insurance is not obligated to pay for said services or that I am not covered by the insurance identified

I am responsible for presenting my insurance card to South East Eye Health Center, Inc., if my insurance changes to a new plan. I am responsible for notifying South East Eye Health Center, Inc., of the change at the time of visit. Without an insurance card I understand I have 15 days to provide South East Eye Health Center, Inc., with the insurance information, or I will be personally responsible for payment in full for service received and or products purchased.

I understand that it is my responsibility to call my Primary Care Provider to request a referral authorization if the reason for my appointment requires one. I agree to call my doctor with this request prior to the visit or within 24 hours after the visit. I agree to be responsible for payment of services if a referral is not granted by my primary care provider.

Signature of Patient_____ Date_____