Name:

Acct#:

# WACO EYE ASSOCIATES

## NOTICE OF FINANCIAL RESPONSIBILITY

Member's Name_____ Member I.D. No._____

Your insurance carrier may not pay for services rendered by Waco Eye Associates Physicians in cases when your primary care physician does not properly refer those services, or when the services rendered are considered non-covered services.
Your insurance carrier may likely deny payment for services rendered by Waco Eye Associates Physicians for the following reasons:

- You do not have a referral from your primary care physician. If you are aware that your insurance carrier requires a referral before being seen by a Waco Eye Associates Physician, please see the front receptionist now to check if the referral has been received.
- This visit will exceed the number of visits previously authorized by your primary care physician and additional visits have not been approved. If this is the case, you will be responsible for the visit.
- Your insurance carrier does not authorize the medical service you are requesting. Almost all insurance carriers consider routine normal eye exams (exam for glasses, contacts, or yearly healthy eye exam checkups) as non-covered services, leaving you responsible for the bill. If you do not want to be financially responsible for this visit, please see the front receptionist.
- Waco Eye Associates does not participate in ANY vision plan services offered by several insurance carriers. These vision plans are structured for Optometric exams, not medical eye exams as provided by Waco Eye Associates Physicians.
- Refractions (glasses prescriptions) are not covered by insurance. The patient will be responsible for payment of the entire $35.00 charge for this service.
- You have insurance but did not give us the information or if you are Self Pay.

### PATIENT AGREEMENT

I have read and understand that the eye services rendered to me by a Waco Eye Associates Physician could be denied payment by my insurance carrier for the reason(s) stated above. If my insurance carrier denies payment, I agree to be personally and fully responsible for payment. If I believe that my insurance carrier will not pay for a rendered service and I have made payment to Waco Eye Associates, and upon filing of claim payment is made, I understand that Waco Eye Associates will reimburse me for the amount covered by my insurance carrier.

_____ _____
Member's Signature Date

_____ _____
Witness Signature Date