NON-COVERED SERVICE WAIVER FORM

(Please print information clearly)

I _____ hereby agree to accept full financial responsibility for the following medical care, glasses, supplies received from The South Eastern Eye Center which is/ are non-covered services based on my current insurance benefits and policy. Your signature below acknowledges the fact that you have been told prior to any of the following services and or purchases being completed today that they may or may not be covered in full or in part by your insurance.

DESCRIPTION

- Contact lens fitting (starting at $55) for soft contacts /price to be determined for hard contacts
- Contact lens re-fit (Starting at $25)
- Full Comprehensive Exam (starting at $110)
- Co-payments, deductibles, co-insurance, and any unpaid amounts by insurance.
- Office visit (Starting at $100)
- ER Visit ($150)
- Refraction ($45)
- No Call/No Show Fee/ Missed Follow-up Fee ($25)
- Frame and lens upgrades ie items not from your kit or insurance provided materials.
    - Anti-reflective coating, transitions, high index, or polycarbonate safety, etc.
- Other items verbally discussed and purchased today. (Purchase of items means the patient was informed of coverage or no coverage per insurance.

Insurance may cover only part of your charges or may be payable directly to you. If the insurance is payable to you directly, you will be responsible for payment upfront and we will provide you with documentation to provide to your insurance company for reimbursement. If your insurance company does not pay as expected, you are ultimately responsible for all

outstanding charges. **Filing your insurance is a courtesy service we provide to our patients and is not required.** You may also pay as a self-pay patient without the use of insurance at your discretion.

Keep in mind that your signature below is:

- An acknowledgment of the fact that you have been given the right to review a copy of our office's HIPPA document.
- Your signature is proof that you have provided our staff with ALL insurance documentation for ALL insurance(s) you have at the time of this visit.
- Your signature is an indication that you understand that with-holding insurance information for the purpose of avoiding co-payments, deductibles, or other reason can been deemed fraud by outside entities and may result in legal action against you or your sponsor. Willingly having other health insurance (OHI) and not using it is unacceptable insurance practice and may result in improper insurance claim submission and you paying for your exam out-of-pocket in full.

These non-covered services will be rendered to you on this day as notated with your signature or your guardian's signature below.

_____

(Name of patient)

_____. _____-___ - _____

(Date of service) (Patient Social Security Number)