FIRSTEYECARE
Vision Made Clear

Patient Authorizations of Release

Patient's Printed Name:_____

I hereby authorize my doctor to release to my insurance carriers any medical or other information needed for all services I receive. I request all insurance payments be made directly to my doctor. I understand that if my insurance company does not pay within 45 days or decides that a service is "non-covered" that a bill will be sent directly to me. I further understand that I am responsible for any deductible, coinsurance, co-pays and refraction fees at the time of services.

I understand that, if at any time, I change my insurance coverage to a managed care plan or change my primary care physician, I am responsible for notifying your office of such changes. If I fail to notify the office or fail to obtain a valid referral prior to my visit, and decide to be seen by First Eye Care, I understand that my services may not be covered by my insurance company and I will be responsible for all charges incurred.

I understand that if I do not have any insurance coverage, I am responsible for all charges at the time of service.

I understand that all re-examinations are subject to a re-exam fee that may not be covered by my vision insurance.

I understand that I have the right to purchase products and request that they be made by First Eye Care instead of my vision insurance company.

Patients who do not keep their appointments or provide 24 hour notice of cancellation will be subject to a charge of $50.

I authorize First Eye Care to contact me via email, text, or phone regarding any further appointments.

X_____ _____

Signature of patient or personal representative **Date**