CONNECTICUT CENTER for sight

Payment waiver form for Non-Covered Services

Our primary concern as your Ophthalmologist is to provide you with the best possible care for your eyes. Follow up visits for treatment of your eye problem(s) are scheduled with the purpose of providing that care and no patients are asked to return more often than is medically necessary.

Recent changes in insurance regulations have limited the number of visits that insurance will allow for certain eye problems even though more frequent visits may be needed to properly treat these conditions. Some insurance companies consider these additional visits "medically unnecessary", consequently refusing to pay for them.

Since we believe each scheduled visit in our office is medically necessary, attempts will be made to collect payment from insurance companies. In the event that payment is denied, you will be responsible for paying for these services. Insurance regulations require that you read and sign the agreement below:

The doctor has informed me (the patient) that payment for the services rendered today may be denied if my insurance considers these services to be "unreasonable and or medically unnecessary". Since both the doctor and I consider these services necessary for the proper treatment of my eye(s), I agree to be personally and fully responsible for payment in the event that my insurance company denies payment and responsibility. I fully understand and agree to these terms.

Print Patient Name **Date of Service**

Signature of Patient or Authorized Representative

Refraction

Measuring for an eyeglass prescription is called a **REFRACTION**. It may not be covered by your insurance. If your insurance company does not pay for this service, you will be billed the **$50 fee**. I understand and accept this policy.

Signature of Patient or Authorized Representative **Date**

Assignment and Release

I, the undersigned, assign directly to Connecticut Center for Sight, LLC all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I herby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on al my insurance submissions.

Signature of Patient or Authorized Representative **Date**