YEARLY PATIENT WAIVER WITH CREDIT CARD OPTION

For the year,_____, I agree that I will provide ALL of my current insurance and billing information, which I assure is up to date at **EACH** appointment. In the event my billing and/or insurance information is NOT correct, I accept full financial responsibility for that visit and understand my exam will not be rebilled.

INITIALS:_____

I understand that (if applicable) it is my responsibility to obtain all necessary referrals and/or prior-authorizations required by my insurance carrier prior to my appointment.

INITIALS:_____

I understand that routine AND medical eye exams may be subject to a denial and/or applied to a deductible, copayment, coinsurance, etc. I am aware that it is my responsibility to pay any outstanding balance after my insurance has processed my claim.

Signature:_____ Date:_____

CREDIT CARD OPTION:

In an effort to minimize patient/ staff interaction, we are giving the patients the option to keep a credit card on file. If you choose to leave your credit card information on file, we will charge you for copayments, contact lens fittings, self pays, and balances after insurance has processed your claim. This may include deductibles, coinsurances, copayments, denials, etc.

-I would like to leave a credit card on file with my patient account - YES NO (please circle option)

-If yes, Credit Card info:

Type of card (please circle): Mastercard Visa AMEX Discover OTHER:_____

Card Number:_____

Expiration:_____ VCode:_____

-Would you like a receipt after each transaction? (please circle) YES NO

Preferred method to receive receipt:

Mailing Address: _____

Email:_____

Signature:_____ Date:_____