myeye consultants

Advance Beneficiary Notice (ABN)

I understand that my insurance may not cover all services rendered. I accept financial responsibility for those services not covered by my insurance.

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our office. If a claim is submitted to your insurance, your health information on this form may be shared with your insurance. Your health information which your insurance sees will be kept confidential by your insurance.

Patient Responsibility For Payment

We do our best to let your know what your insurance requires you to pay for your portion of the exam, glasses, and contacts. However all quotes for co-pays and co-insurance prices are subject to change based on billing your insurance. We will adjust your account accordingly.

☐ I understand and accept the above statement.

_____

Patient Name

_____ _____

Signature of patient or person acting on patient's behalf Date