EYE CLINIC OF AUSTIN

Proof of Insurance Waiver

Appointment Date: _____Time:_____ Provider: ◯Henderson ◯Falknor ◯Prosise

Insurance Plan:_____

Your insurance plan requires you to provide your identification, pertinent demographic registration information, and proof of insurance coverage to every doctor you visit, on every visit.

I, _____, cannot provide proof of my insurance and/or my identity and/or my eligibility with my insurance cannot be determined for my appointment with the doctor today.

I understand and agree that I will receive services from the Eye Clinic of Austin without proof of insurance. Since I cannot provide proof of insurance and/or my eligibility cannot be determined, I agree at check-out to make complete payment for today's services rendered and understand that there will be no billing by statement or credit extended.

If I provide proof of my insurance (preferably an insurance card) and identity to the Eye Clinic of Austin within two (2) business days, I understand that the billing department of Eye Clinic of Austin will file a claim on my behalf to my insurance plan. If the Eye Clinic of Austin receives payment for the services, I will be reimbursed my out-of-pocket less any co-payments or deductibles that were applied.

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I certify that this Proof of Insurance Waiver has been fully explained to me, that I have read it or had it read to me, that all blank spaces have been filled-in prior to my signing and that I understand and agree to its contents.

_____ _____

Patient/Guardian Signature Printed Name if Guardian

_____

Date

_____

Eye Clinic of Austin Witness

Revised 12/20/11