Kind Eyecare

Date: _____

I understand that if for any reason my insurance, _____, does not cover today's visit, I will be financially responsible for all services rendered, including office visit fees and/or any testing charges.

I understand that this includes insurances that require a referral and that without a referral from my Primary Care Physician; today's will be subject to out of network benefits, deductibles, co-insurance and co-pays. If the insurance policy does not have out of network benefits, I will be responsible for the full charge. If I am able to supply a properly dated referral, I understand that KLH Eyes LLC will then file to my insurance on my behalf.

Having read this form, my signature below acknowledges that I will be financially responsible and voluntarily give my authorization and consent.

_____
Patient Name (Print)

_____ _____
Patient (or person authorized to sign for patient) Date

_____ _____
Witness Date

Kind Eyecare
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