



**PLEASE PRINT and complete this form as clearly and completely as possible and BRING IT WITH YOU to your appointment. This form cannot be submitted online. Thank you for your cooperation.**

The following information is provided for the benefit of our patients, so that we may better serve your needs.

It is important that each patient understands their own and their dependents medical and/or vision coverage in advance of their office visit. We cannot practically keep track of individual plan details, such as exclusions, coverage amounts, eligibility rules and referral requirements for each and every patient. The patient must be responsible for determining what their individual benefits are. It is imperative that you contact your insurance carrier to find out what your plan covers, and what you may expect to pay out of pocket. Ask your carrier when you are eligible for coverage, especially vision coverage and find out what is not covered, (for instance contact lens exams). Remember to ask if you need to get a referral from your family doctor to cover your visit with us. We request you contact your insurance ahead of time to verify that the provider you are seeing with Eye Consultants of Pennsylvania is participating at your appointment location with your plan.

Educating yourself about your insurance benefits ensures that you will not be unexpectedly billed for supplies or services you received from our office. We will always try to assist with any service related questions.

Thank you for your support, understanding and cooperation.

I understand that I must play a key role in understanding my insurance/vision plans and that I am ultimately responsible for anything that my plan does not cover.

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Patient's Name: (Please Print)

Patient's Date of Birth:

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Signature: (Patient or Parent if Minor)

Date: