PLANO EYE Associates-East

Timothy A. Wright O.D.
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RETURNING PATIENTS

Acknowledgement of Receipt

I acknowledge that I have read or have had the opportunity to read the Notice of Privacy Practices available at the front desk or online).

Patient Name (Printed) _____Date:_____

Signature of Patient or Guardian:_____

Insurance and Payment Authorization: We need copies of **both** Medical **AND** Vision.

I request that payment for services rendered to be made on my behalf to Plano Eye Associates- East. I authorize the release of information required to process any insurance claims. I permit my signature and/or the policy holder's signature along with copies of cards to be kept on file for future visits and insurance claims indefinitely.

I understand that with the varying nature of vision and health insurance policies, there may be additional fees or eligibility denials that my insurance dictates upon the initial filing of the claim from Plano Eye Associates- East. I understand and agree that I (or the guarantor) am financially responsible for any and all charges insurance does not cover regardless of benefits quoted. I understand that all outstanding balances will accrue a late fee if arrangements are not made, and accounts over 90 days may be forwarded to a collection agency.

Signature: _____ Date: _____