

South East Eye Health Center, Inc.
D.B.A. SOUTH EAST EYE FAMILY VISION CENTER
ADVANCED BENEFICIARY NOTICE

SECTION 1:
REGARDING INSURANCE PLAN NOTIFICATION

I am responsible for presenting my insurance card to South East Eye Health Center if my insurance changes to a new plan. I am responsible for notifying South East Eye Health Center of the change at the time of the visit. Without an insurance card, I understand I have 15 days to provide South East Eye Health Center with the insurance information, or I will personally be responsible for payment in full for service received and/or products purchased.

SECTION 2:
REGARDING NON-COVERED SERVICES AND PRODUCTS

I understand that my eye exam, contact lens fitting or refitting, contact lens instruction, prescription eyeglasses and/or contact lenses may not be a covered benefit of my health insurance plan. I agree to be responsible for payment for services received and/or products purchased if these benefits are not covered by my insurance plan.

SECTION 3:
REGARDING REFERRAL AUTHORIZATIONS

I understand that it is my responsibility to call my primary care provider to request a referral authorization if the reason for my appointment requires one. I agree to call my doctor with this request prior to the visit or within 24 hours after the visit. I agree to be responsible for payment of services if a referral is not granted by my primary care provider.

Patient Signature _____

Date _____