

Untitled

Please bring your insurance card(s) on your visit that we may make a copy to complete your records.

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above insurance and assign directly to Kats Eye Care, P.C. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. By signing this statement, I understand that my vision and/or health insurance coverage is a contract between myself and my insurance company. Although Dr. Kats and staff have made every effort to verify my benefits before my appointment, no guarantee can be made that the information received is accurate since incorrect information may be provided by my insurance company from time to time. I understand that it is ultimately my responsibility as the patient to understand my vision and/or health insurance coverage as well as handle any charges my plan does not cover.