METROLINA EYE ASSOCIATES

A Clear Vision of Excellence

SELF-PAY FORM

Patient Name:_____ DOB:_____

Patient ID #:_____ Date of Service:_____

[ ] I do not have medical and/or vision insurance to cover my visit today.

[ ] I have medical and/or vision insurance that Metrolina Eye Associates does not accept. I have been fully informed and agree that **no claim will be filed to my insurance for the services I elect to have as a self-pay patient.**

[ ] I have medical and/or vision insurance which requires an Insurance Referral from my PCP, which Metrolina Eye Associates has not received. I elect to proceed with my scheduled visit today understand that a claim will not be sent to my insurance carrier and that I am fully financially responsible for the services rendered.

[ ] Other:

_____

_____

I understand payment in full is my responsibility and is due on the date that services are rendered by the providers at Metrolina Eye Associates. I understand that a claim will not be submitted to my insurance carrier on a future date under any circumstances for the services rendered.

Patient's Name (please print): _____

Patient's Signature (or Parent, if child): _____

Date: _____ Staff Witness:_____