UNAUTHORIZED VISIT WAIVER

Appointment Date: __________________ Time: _________ Provider: □ Henderson □ Falknor □ Prosise

Insurance Plan: ____

□ No out-of-network benefits □ not applicable

I, ____, understand and agree that my insurance policy is a managed care plan and without prior authorization or referral from either my primary care physician or my insurance carrier, all services rendered to me on this date will be my responsibility to pay.

I understand that my insurance plan will not be sent a claim by the billing department at Eye Clinic of Austin, even if I obtain authorization or referral after my appointment. The Eye Clinic of Austin will provide me with the items charged so that I may file a claim with my insurance, should I decide to do so.

I further agree to make complete payment for today's services rendered at check-out and understand that there will be no billing by statement or credit extended.

□ File out-of-network benefits □ not applicable

I, ____, understand and agree that my insurance policy is a managed care plan and without prior authorization or referral from either my primary care physician or my insurance carrier, all services rendered to me on this date will be my responsibility to pay.

I understand that because my insurance plan offers out-of-network benefits I have agreed not to seek a referral or authorization for services today, and I have requested that the Eye Clinic of Austin file an unassigned claim for out-of-network benefits to my insurance plan. This claim will be filed as a courtesy and, if denied, will not be appealed by the staff at Eye Clinic of Austin. Any appeals or refiling of out-of-network claims will have to be filed by me.

I further agree to make complete payment at check-out for today's services rendered and understand that the claim filed will indicate that Eye Clinic of Austin did not accept assignment of the claim. This should indicate to my insurance that any payments should be sent to me directly. If the Eye Clinic of Austin is paid by my plan, they have agreed to refund me the amount paid by my insurance plan.

□ Emergency appointment □ not applicable

I, ____, understand and agree that my insurance policy is a managed care plan and without prior authorization or referral from either my primary care physician or my insurance carrier, all services rendered to me on this date may be my responsibility to pay.

I have contacted my primary care physician's office and/or my insurance plan to request an authorization or referral for this urgent appointment, and have been assured by them that the Eye Clinic of Austin will receive this information within 48 hours.

I understand that if the Eye Clinic of Austin does not receive the authorization or referral for today's urgent visit within 48 hours that I will be fully responsible for all charges incurred. I understand that under these circumstances my insurance plan will not be sent a claim by the billing department at Eye Clinic of Austin.

In the event that a referral or authorization is not provided to the Eye Clinic of Austin, I will be sent a statement for all services rendered, and I agree to pay fee-for-service for the entire balance upon receipt. The Eye Clinic of Austin will provide me with the items charged so that I may file a claim with my insurance, should I decide to do so.

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I certify that this *Unauthorized Visit Waiver* has been fully explained to me, that I have read it or had it read to me, that all blank spaces have been filled-in prior to my signing, and that I understand and agree to its contents.

____ _______________________________________

Patient/Guardian Signature | Printed Name if Guardian

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Date

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Eye Clinic of Austin Witness

Revised 12/20/11