COOSA EYE
associates, pc
A Family Eye Care & Optical Center

Dr. P. Duncan Roy, Jr.
Optometry

- Ocular Disease Diagnosis and Treatment
- Adult and Pediatric Eye Care
- Contacts
- Second Opinions
- Low Vision Evaluations
- Pre-evaluation for Surgery to Reduce Myopia (Nearsightedness)
- Orthokeratology

Patient Name_____ DOB_____ SS#_____

Subscriber Name _____DOB_____SS#_____

Primary Insurance Co. _____ Ins. # _____

Secondary Insurance Co. _____ Ins. # _____

***Please initial each statement.**

Insurance Assignment and Release

- I, the undersigned, certify that I (or my dependent) have insurance coverage with the above named company and assign directly to Dr. P. Duncan Roy, Jr. / or his associates all insurance benefits, if any, otherwise payable to me for services rendered. _____*
- I understand that insurance is a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. _____*
- I understand that I am financially responsible for all charges whether or not paid by insurance. Coosa Eye Associates, PC/ Dr. Roy will submit an insurance claim as a courtesy. However, if that claim is denied **for any reason**, I am responsible for payment of all applicable fees without question. _____*
- Certain ophthalmic tests like refractions are an integral part of a complete eye exam. However, many insurances such as Medicare consider this "routine eye care" and not a covered medical service. I understand that I am financially responsible for all charges for these non-covered medical services. _____*
- I authorize the use of this signature on all insurance submissions. _____*
- I hereby authorize the doctor to release all information necessary to secure the payment of benefits. _____*
- I acknowledge that I have received and signed your Patient Information Privacy Notice. _____*

Patient Signature _____ Date_____