GLAUCOMA CENTER OF SAN FRANCISCO

## SELF-PAY PATIENT DISCLAIMER

☐ **Patients Without Health Insurance Coverage**

As a patient without health insurance coverage, I, _____, understand that I am considered a Self-Pay patient. As such, I understand that I will be asked on the day of my visit to pay in full the charges incurred from my visit. Should I be unable to do so, a bill will be sent to me in the mail.

_____ _____

Patient Signature Date

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☐ **Patients Without Proof of Health Insurance Coverage**

As a patient without a health insurance card to prove my health insurance coverage, I, _____, understand that I am considered a Self-Pay patient. As such, I understand that I will be asked on the day of my visit to pay in full the charges incurred from my visit. Should I be unable to do so, a bill will be sent to me in the mail. Once I have presented proof of coverage in the form of an insurance card and the charges have been paid by my insurance company, I will be reimbursed by the Glaucoma Center of San Francisco.

_____ _____

Patient Signature Date

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☐ **Patients With Health Insurance Coverage Needing Verification**

I, _____, understand that the health insurance plan that I have presented to the Glaucoma Center of San Francisco may not be accepted, and consequently not cover the

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that be the case, I understand that I will be considered a Self-Pay patient and, as such, will be billed in full for the charges incurred from my visit.

_____ _____

Patient Signature Date

55 Stevenson Street, San Francisco, CA 94105 Tel: (415) 981-2020 Fax: (415) 981-2019