

Glaucoma Center of San Francisco

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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

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

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
charges incurred for my visit. Should 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