GLAUCOMA CENTER OF SAN FRANCISCO

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John Hetherington, Jr., M.D., *1930-2020*

INSURANCE AND SELF-PAY 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 am not being denied necessary medical care and 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 with Non-Participating Health Insurance Coverage**

I, _____, have been informed that the Glaucoma Center of San Francisco and its physicians are not on the participating panel for my insurance carrier and understand that I am considered a Self-Pay patient. As such, I understand that I am not being denied necessary medical care and 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 am not being denied necessary medical care and 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 will be billed on my behalf, but 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. I further understand that I am responsible for all charges due to copays and deductibles.

_____ _____
Patient Signature Date