Advanced VisionCare

" Quality EyeCare Is Our Promise "

Patient Name _____

Permission for Filing Insurance

Your signature below gives Advanced VisionCare of North Arlington the permission to file an insurance claim on your behalf.

_____ _____

Signature of Patient or Patient's Representative Date

Patients with Vision and/or Medical Insurance

In the event that your insurance states that you are not eligible for coverage at the time of service, or determines that you are eligible for a reduced level of coverage, by signing this statement, you hereby agree to be financially responsible for any and all charges incurred by you that are not paid by your insurance provider.

_____ _____

Signature of Patient or Patient's Representative Date