peak VISION CLINIC

KEELY HOBAN, OD ▪ DAVID CARKNER, OD ▪ EMILY BEE, OD

Medical Services Disclaimer

I, _____, understand that my Doctor has recommended certain medical services that may not be approved or may not be covered for payment by the insurance company I have listed below. By my signature, I understand that my routine vision insurance company will not contribute toward these services and my medical insurance will therefore be billed. I understand that my annual deductible and/or coinsurance and/or copays may apply and I will be responsible for those amounts should my insurance company apply those fees. If my insurance company does not pay towards these services, I understand that I will be responsible for the cost of these services. I also understand that Peak Vision Clinic is not responsible for obtaining a referral should my insurance company require one.

_____ _____

Medical Insurance Company *Identification Number*

_____ _____

Patient Signature (or responsible party) *Date*

Medical Eye Care Statement

To: All insurance companies/carriers, employers, and medical service providers involved with my care:

At the time I sought out emergency eye care services, it was my belief that waiting to receive care would result in a worsening of my condition. When I considered the change in my vision and/or the appearance of my eyes, I believed that immediate evaluation and treatment by an eye care specialist was the only prudent course of action.

_____

Print Patient Name

Medical Insurance Company:_____

_____ _____

Patient Signature (or responsible party) *Date*

503.288.6181 | peakvisionclinic.com | portland@peakvisionclinic.com
503.692.2020 | peakvisionclinic.com | tualatin@peakvisionclinic.com