I would like to use: ☐ Medical insurance ☐ Vision insurance ☐ No insurance; patient pay
I understand final determination on what insurance will be billed is determined by my diagnosis.

_____ _____
Patient's or Legal Representative's Signature Date

Patient's Name: _____
I have received a complete copy and agree to the terms of Vision Institute of Michigan, PC (VIM) Notice of Privacy Practices/Consent for Treatment.
In consideration of the services provided to me, I agree to pay all charges not covered by my insurance company, or other applicable health benefit provider. I understand that it is my responsibility to:

- Know what my insurance benefits cover, including:
  - Testing, procedures, surgeries, office visits and hospitalizations
  - Co-pays and deductibles
  - Pre-authorization requirements for any services prior to my visit
- Fully pay all deductibles, co-payments, non-covered services by cash, check or charge on the day the service is provided – unless prior arrangements have been made between the office manager and myself.
- Compensate VIM for all charges for services rendered despite any disputes or disagreements between my insurance company and myself.

_____ _____
Patient's or Legal Representative's Signature Date

I authorize VIM to distribute to me, any necessary or recommended educational/promotional information as directed by my Physician. I may be contacted by phone or email.

☐ Yes ☐ No _____
Patient to initial

I approve of the sharing of my health and billing information with the following:

_____ _____
Name Relationship

_____ _____
Print Patient's Name Date

_____ _____
Patient's or Legal Representative's Signature Witness Signature

Patient Account # _____