

Patient Waiver

I, _____,
understand the policy of Legarreta Eye Center,
which is listed below and that I will be
responsible for today's charges **IF** I do not notify
the office of any changes in my insurance.

- Not all procedures or services may be covered under my insurance and may require a referral or prior authorization, which is my responsibility.
- This office requires 24 hour notice to cancel an appointment; otherwise I will be charged \$25
- A \$25 fee will be assessed to me for no show-no call appointment.
- Co-pays are required at time of service; I may incur a service fee if a bill has to be sent to me.

Initials

date

initials

date

Initials

date

initials

date