LEGARRETA
EYE CENTER

Patient Waiver

I, _____,
understand the policy of Legarreta Eye Center, which is listed below and that I will be responsible for today's charges as well as any future visit 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 a 24 hours notice to cancel an appointment; otherwise I will be charged a $50.00.

- A $50.00 fee will be assessed to me for a no-show, no-call appointment.

- Co-pays are required at time of service. I may incur a service fee of $25.00 if a bill has to be generated and sent to me.

_____ _____

Patient Signature Date