Utah Eye Associates
State-of-the-art medical and general eyecare

150 South 1000 East, Suite 100
Salt Lake City, UT 84102
Phone: 801-363-2851
Fax: 801-363-7186
Website: www.UtahEyeAssociates.com

Patient's Insurance Responsibility

I, _____, understand that Utah Eye Associates will bill

(a) First my medical insurance for the services provided, then

(b) Secondly my vision insurance, if they are participating providers.

Unless specifically stated, at the time of service, Utah Eye Associates will not bill any insurance for glass or contact lenses. I also understand that if I do not provide all current insurance information, at the time of service, I will be responsible for all charges. I will provide the following:

Name of Primary Insured: _____

Date of Birth: _____

Address of Insured: _____

Relationship of Insured: _____

Utah Eye Associates is not responsible to file any insurance, if such information is provided, after the date the services are rendered. Utah Eye Associates may charge a filing fee, to the patient, at any time to file any insurance. I understand that it is not the responsibility of the above office to negotiate payment and/or coverage for any services rendered.

I understand that filing for insurance coverage, except for Medicare and Medicaid, is a service of Utah Eye Associates. I agree to pay all outstanding balances that are 60 days past due and all collection fees, if necessary, which can be up to 40% of the balance due.

The undersign fully understands the above and the patient/guardian accepts the responsibility for all charges assessed.

_____ _____

Utah Eye Associates Patient/ Guardian

_____ _____

Date Date