Dr Kevin Krajewski and Dr Tuesday Hennessy
12810 West Alameda Parkway Suite B
Lakewood CO 80228

INSURANCE LIABILITY POLICY

Insurance benefits are subject to the limitations, deductibles and/or co-pays of your plan. It is the patient's responsibility to understand insurance benefits, including and co-pays, deductibles, and limitations. Due to privacy laws, you may need to assume responsibility and contact your insurance company for questions regarding coverage and provider listing. Your insurance may or may not pay for all services provided by Foothills Vision Center. Benefits will be determined at the time of claim processing. Any amounts not paid by insurance will be the patient's responsibility. If this balance exceeds 120 days, your account will be transferred to collections. Authorization of insurance is not a guarantee of payment.

Patient Name ________________________________I understand the above and agree to its terms.

Parent/Guardian *may sign for minor if applicable.*
Signature **X**_______________________________ Date___________________
Medical Insurance Name_____________________________
ID#________________________

Medical VS Vision exam Policy and Procedure

Most of our patients have both medical and vision insurance. They are very different in the types of services that they cover when you come in for an office visit. Routine vision insurance *(VSP, Eyemed, Spectera, Superior Vision, etc.)* is used to determine eye glass and contact lens prescription and helps pay for glasses and contacts in some cases. Basic vision insurance does not deal with or cover medical visits for such as eye infection, cataracts, diabetes, glaucoma, floaters etc. Medical insurance *(Medicare, BCBS, Cigna, UHC, etc.)* is used when a medical diagnosis or medical condition is present.

If we are on your insurance's panel we will bill your medical plan on your behalf; in the event that your claim is denied or is transferred to your deductible you would be responsible, and we would send out a statement for the charges. You are responsible for all copays and deductibles determined by your insurance company.

I understand the above paragraph's and authorize Foothills Vision Center to file my insurance claims and agree to comply with the policies and procedures.

Print Name_______________________________Signature
X_____________________________Date___________