



COASTAL EYE CENTER

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## ACKNOWLEDGEMENT OF NON-PARTICIPATION WITH INSURANCE CARRIER

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

I have been informed that Coastal Eye Center and its physicians are not on the participating panel for my insurance carrier:

Name of insurance: \_\_\_\_\_

I am **not** being denied necessary medical care and my insurance will be billed on my behalf with any benefits assigned to Coastal Eye Center and its physicians. However, I am aware that any benefits available will be processed under the **out of network** provisions of my insurance carrier. I further understand that this shall mean I am responsible for all charges such as copays and deductibles.

I have been allowed to ask questions regarding my insurance and at this time I understand and acknowledge that I am responsible for any expenses incurred in my treatment and desire to be treated in this office.

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Witness