# Waiver of Liability Notice of Noncoverage:

Private Insurance ONLY

Sun Eye Care, P.A.

The **Waiver of Liability Notice** is **used** to provide voluntary notification of financial liability for items or services that your private insurance may not cover for the services(s) listed below. Your private insurance does not pay for all your healthcare costs. Private insurance only pays for covered items and services based on your benefits and it is the responsibility of the insured to be aware of covered benefits. The fact that your insurance may not pay for a particular item or service does not mean that you should not receive it. However, you need to make a choice about receiving this/these health care item(s) or service(s).

***Private Insurance may not pay for the following item(s) or service(s).***

| | | | |
|---|---|---|---|
| Visual Field Test **$118-169** | (CPT Codes: 92081, 92082, 92083) | Corneal Topography **$115** | (CPT Code: 92025) |
| OCT **$118** | (CPT Codes: 92133, 92134) | Fundus Photos **$136** | (CPT Code: 92250) |
| Tear Lab **$53-106** | (CPT Code: 83861) | Pachemetry **$111** | (CPT Code: 76514 |
| B-Scan **$326** | (CPT Code: 76512) | Refraction Test **$42** | **OTHER:** |

***Reason for non-payment:*** Non-covered benefit service(s) and/or item(s)*:* _____

Please be advised that your insurance company will not decide whether to pay unless you receive the above item or services. If your insurance denies payment, you will be fully responsible for payment. That is, you must pay personally, either out of pocket or through any other insurance that you may have. You may appeal your insurance's decision.

Your private insurance allows that we may bill you for items or services and that you may have to pay the bill while your insurance makes its decision. If your insurance does pay, we will refund to you any payments made. The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully.

- Ask us to explain if you do not understand why your insurance may not pay.
- Ask us how much these items or services will cost you. (Estimated total cost: S_____)

PLEASE CHOOSE ONE OPTION

□ **YES**. _____ (Initial) I want to receive these items or services. Please submit my claim to my private insurance. I agree to accept financial responsibility in the event my insurance chooses not to pay.

□ **YES**. _____ (Initial) I want to receive these items or services, but do not bill my insurance. You will be asked to pay item(s) or service(s) at the time of service (***Discount Private Pay Rates Available***). I cannot appeal if insurance is not billed.

□ **NO**. _____ (Initial) I have decided not to receive these items or services. I understand that you will not be able to submit a claim to my insurance and that an appeal to my insurance will not be made.

_____ _____

(Patient Signature/Responsible Party) (Date)

_____ _____

(Witness) (Date)