Dr. Troy Coker Family Eye Care

Please be advised if you are using insurance for today's visit, this is a contract between you and your insurance company..... Not Dr. Coker Family Eye Care. If your insurance company has not reimbursed our office in full within 90 days you will be billed for the charges rendered on that date of service.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of the accout for any professional services rendered. I have read and completed the information and I certify this information to be true and accurate to the best of my knowledge. I will notify the office of any change in my status.

Signature ______________________________ Date ______________

Privacy Notice

It is often necessary to use and disclose health information in order to treat you, To obtain payment for our services, and conduct healthcare operations involving our office. The "Notice of the privacy practice" we have posted in the office describes the uses and discloser in detail. You may request a paper copy for your records. I acknowledge that I have been informed of the privacy practice.

Signature ______________________________ Date _____________