Metro Eyes

260 Maple Ave. E
Vienna, VA 22180
PH#703-255-1502

I, ________________________________, am aware that my health insurance may not cover the services that I receive today from Metro Eyes as I have:

Circle all that apply

1. Insurance which this facility does not participate with
2. Not presented my insurance card.
3. Not presented a referral or authorization upon arrival.
4. Presented an insurance card which may consider Metro Eyes as out of network provider.

I understand and agree that I am ultimately responsible for payment, which is requested at the time of visit. I also understand that it is my responsibility to present my insurance card within 48 hours if I wish for Metro eyes to bill my insurance.

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Patient/guardian Signature and Patient's DOB

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Witness signature

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Date