Payment for Professional Services due at the time rendered.

We accept the following forms of payment: VISA, Mastercard, Cash, Check (in state with valid driver's lic.)

Insurance Information:

Please present any insurance identification cards to the receptionist prior to examination. Check if you are currently enrolled in any of the following:

_____ Tricare (Standard, Prime or For Life)

_____ Medicare

_____ Medicaid

_____ Other Primary Insurances: _____

_____ Other Secondary Insurance: _____

Signature Authorization:

I request payment of authorized medical insurance benefits be made to myself, or on my behalf, for any services furnished me by the staff and doctors affiliated with Dr. Hanna and Associates, or to any party which accepts assignment. I understand that I am responsible for any procedures not covered by my insurance company for any reason. I understand that I am responsible for any co-payments, deductibles, contact lens fittings, eyeglasses or other non-covered services.

I authorize the release of any medical information to the authorized third party necessary to process claims form services rendered.

I acknowledge that all information in my medical records is confidential and will be handled only by support personnel of Visionworks and by the associates of Dr. Hanna and Associates. I understand that all professional fees are non-refundable.

Patient or Guardian's signature _____ Date _____

Dr. Hanna's services and products are rendered to the patient, not the insurance company. **The patient is directly and ultimately responsible to this office for payment of any fees denied by your insurance company.** Insurance submitting is a courtesy that we do for you. Thank you for your cooperation.

Hanna Eye Care & Associates

_____ _____

Patient Date