

Foothills Vision Center
Dr Kevin Krajewski/ Dr Patrick Nelms
12792 West Alameda Parkway Suite F
Lakewood CO 80228

INSURANCE LIABILITY FORM

Insurance benefits are subject to the limitations, deductibles and/or co-pays of your plan. It is the patient's responsibility to understand insurance benefits, including and co-pays, deductibles, and limitations. Due to privacy laws you may need to assume responsibility and contact your insurance company for questions regarding coverage and provider listing. Your insurance may or may not pay for all services provided by Foothills Vision Center. Benefits will be determined at the time of claim processing. Any amounts not paid by insurance will be the patient's responsibility. If this balance exceeds 120 days the account will be transferred to collections. Authorization of insurance is not a guarantee of payment.

I understand the above and agree to its terms.

Signature _____

Date _____

HIPAA COMPLIANCE ACKNOWLEDGEMENT OF RECIEPT

_____ Yes, I would like a copy of the Notice of Privacy.

_____ No, I would not like a copy of the Notice of Privacy.

I give permission to release information to _____

Patients Name: _____

Patients Signature: _____