SHILLINGTON EYE ASSOCIATES, LLC
453 E. Lancaster Ave.
Shillington, PA 19607
Tel: (610) 775-3321

NOTICE OF EXCLUSION FROM INSURANCE BENEFITS

THERE ARE ITEMS FOR WHICH YOUR INSURANCE COMPANY WILL NOT PAY.

- Your insurance company does not pay for all care, even those tests your optometrist may recommend based on his or her expertise.
- This form acknowledges specific services / procedures not covered by your insurance company and your estimated additional out-of-pocket costs for these services.
- You are responsible for payment for items not covered by your insurance company.

Please read this notice carefully so you can make an informed decision about your care.

Patient Name_____ Patient Date of Birth_____

Non Covered Services

Optomap	Contacts Lens Fitting
Refraction / Vision Analysis	Frames and Lenses
Contact Lens Evaluation	Contact Lens Supply

*** I understand that I am responsible for any services/products that my insurance company does not cover.**

*** I understand that the balance given is an ESTIMATE of what my insurance company may cover/reimburse and my balance may change due to the insurance claim processing.**

*** I understand that I am responsible for any and all co pays/ deductibles that my insurance company does not reimburse.**

Patient Signature	Date
Parent/Guardian Signature	Date