Enfield Eyecare Associates, L.L.P.
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Christopher L. Agro, O.D.
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Patient Name: _____ Acct #: _____

FINANCIAL DISCLAIMER

In some cases, routine vision exams are covered by insurance. However, if you receive certain additional services during your visit, you may have to pay an out-of-pocket cost such as a copay, coinsurance, or deductible. For the most accurate information regarding your benefit coverage, please contact your insurance company directly. Your vision and eye health are our highest priorities, and we look forward to providing you with quality care and services.

Services that could lead to additional charges during your visit include, but are not limited to:

- Contact lens evaluations and fitting fees
- Dilated fundus exams, retinal photography, visual field tests, and optic nerve scans for medical conditions such as: diabetes, glaucoma, and macular degeneration
- Refraction – the determination of a prescription for glasses and/or contact lenses

Please note when ordering eyeglasses, payment is expected in full at the time the order is placed.

I understand that not all services I receive may be covered by my insurance plan and/or may apply towards my deductible. Additional services or procedures performed at my request or at the provider's recommendation may result in an out-of-pocket cost to me based on the contract between myself and my insurance plan.

ACCOUNTS 60 DAYS PAST DUE ARE SUBJECT TO A $25 LATE FEE.

I acknowledge that I am responsible for these out-of-pocket expenses.

Patient/Guardian Signature: _____ Date: _____