



200 Canal View Blvd., Suite 102, Rochester, NY 14623-2809
Phone: 585.461.5330 ~ Fax: 585.461.9895

PATIENT INSURANCE RESPONSIBILITY AGREEMENT/WAIVER

Please print unless noted.

Patient's name: _____ DOB: _____

Patient's signature: _____ Date: _____

Person responsible for payment: _____

Signature: _____ Date: _____

Primary Insurance: _____ ID# _____

Subscriber's name: _____ DOB: _____

Secondary Insurance: _____ ID# _____

Subscriber's name: _____ DOB: _____

To be answered only if your Secondary Insurance is Medicare:

Are you disabled? Yes No If yes, enter date of disability _____

By initialing these statements you declare that you fully understand these terms and agree to receive care from Neuro-Ophthalmology Consultants of Rochester (NOCR).

Worker's Comp/No Fault:

Neuro-Ophthalmology Consultants of Rochester
200 Canal View Blvd., Suite 102
Rochester, NY 14623
Tel: 585-461-5330 Fax: 585-461-9895

_____ I understand NOCR ***does not*** accept and ***will not*** submit claims to Worker's Comp or No Fault Insurance.

_____ I acknowledge that I will be responsible for full payment for any service rendered in a Worker's Comp or No Fault case on the day service was received if I failed to make full disclosure.

Insurance:

_____ I hereby authorize all medical records and other relevant information necessary to process medical claims and receive payment to be released to NOCR.

PATIENT INSURANCE RESPONSIBILITY AGREEMENT/WAIVER – 2

_____ I attest that the insurance information I have provided is true.

_____ If any of my insurance information changes, I am responsible for informing NOCR immediately. If I fail to notify NOCR of these changes, I am responsible for charges that will not be covered by insurance due to inaccurate information.

Copayment:

_____ Any copayment required by my insurance is due at the time of my office visit. If I fail to tender my copayment on the day of service, there will be an additional \$10 fee. Returned checks will result in a fee of \$25.

Referrals:

_____ If my insurance requires a referral, I am responsible for obtaining that referral from my primary care doctor. If a referral to NOCR is not obtained, I will be responsible for any charges incurred.

Chart ID: _____

Neuro-Ophthalmology Consultants of Rochester
200 Canal View Blvd., Suite 102
Rochester, NY 14623
Tel: 585-461-5330 Fax: 585-461-9895