

**Dr. David J. Matthews, OD Dr. Jeffery S. Pockl, OD**

I understand that Devine Eyes will make every effort to help me get the maximum benefit from my insurance plan(s). However, I also understand that Devine Eyes cannot guarantee the every item billed to my insurance(s) will be covered by my plan.

I further understand that the staff of Devine Eyes will gladly answer any questions I may have about the coverage issues before services are rendered.

Finally, I understand that insurance usually does not pay for any service in full and that my plan(s) may not cover some services at all. I agree to pay for any service that my insurance company does not cover. I also agree to pay any co-pays at the time of service, and any co-insurance and deductible amount left on my account after my insurance has paid.

Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient/Guardian or Legal Representative:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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