Angela Tsai, O.D., F.V.A.O.
Samuel C. Smart, O.D., F.V.A.O., F.A.A.O.
Bradley Church, O.D., F.V.A.O.

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Phone: 540.373.3021 Fax: 540.373.5565

INSURANCE

I request payment of authorized insurance benefits for any services furnished to me, be made on my behalf, to Premier Eyecare, Angela Tsai, O.D. & Associates, P.C.
I authorize any holder of medical information about me to be released to my insurance company and its agents any information needed to determine the benefit(s) payable for related services. **I understand I am responsible for charges not paid by my insurance plan and payment is expected at time of service.**

Signature_____ Date___/___/_____

Print Name _____

VISION SERVICE PLAN (VSP) PATIENTS ONLY

An eye examination for a VSP patient includes dilation that is covered. By signing this form you are stating you have been offered the dilation included in the exam but have chosen not to be dilated, unless medically necessary, and have the Optomap done.

Signature_____ Date___/___/_____

Print Name _____