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OPHTHALMOLOGY  
Diseases and Surgery of the Eye  
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SPINAK MEDICAL EYE CENTER  
169 NORTH MIDDLETOWN ROAD  
PEARL RIVER, NEW YORK 10965

Patient's Name \_\_\_\_\_  
(please print)

It is the responsibility of all our patients to confirm our participation with your particular insurance company. While we are privileged to be able to provide Ophthalmology services to you, it is very hard for us to know all the individual requirements of every insurance plan. It is the patient's responsibility to be aware of the current terms of your insurance policy.

Some insurance plans differ within a company depending on the type of contract you or your employer has negotiated. Providing quality Ophthalmological care for patients is our primary concern. We are willing to provide that care within your insurance company's guidelines. If there are any changes of service between appointments, please let us know at your time of service.

Be prepared to pay for your copay, coinsurance, deductible, or any non covered service (such as a REFRACTION) at the time of your visit. If you are an uninsured patient, payment in full is due at the time of service. Our office accepts cash, checks, and all major credit cards

If your insurance company requires you to have a referral from your primary care physician, you must present your referral at the time of your visit. Patients without a valid referral will be rescheduled.

If you do not inform us of any special requirements with your contract and we order medically indicated services that are not covered by your policy, the office will have no option but to bill you directly for those services. Those charges will be the responsibility of the patient.

With your cooperation, you should receive all the benefits offered to you, and we can concentrate on caring for your Ophthalmological needs.

**I HAVE READ AND UNDERSTAND THE OFFICE POLICY  
STATED ABOVE AND I AGREE TO ACCEPT RESPONSIBILITY  
AS DESCRIBED.**

Signature \_\_\_\_\_ Date \_\_\_\_\_