Boston Foundation for Sight

Patient Waiver Agreement

I understand that I have an obligation to pay for all services that are not considered covered benefits by my insurance company. I agree to pay for all services should payment be denied by my insurance company for any reason including my failure to provide a required referral.

I also agree that I will pay for all services should payment be denied for my failure to provide Boston Foundation for Sight with my current insurance information at the time of my visit.

Date: _____

Signature: _____

Name: _____