

**KOZOL VISION CENTER, INC.  
ADVANCED BENEFICIARY NOTICE**

**SECTION 1:  
REGARDING INSURANCE PLAN NOTIFICATION**

I am responsible for presenting my insurance card to Kozol Vision Center if my insurance changes to a new plan. I am responsible for notifying Kozol Vision Center of the change at the time of the visit. Without an insurance card, I understand I have 15 days to provide Kozol Vision Center with the insurance information, or I will personally be responsible for payment in full for service received and/or products purchased.

**SECTION 2:  
REGARDING NON COVERED SERVICES AND PRODUCTS**

I understand that my eye exam, contact lens fitting or refitting, contact lens teaching, prescription eyeglasses and/or contact lenses may not be a covered benefit of my health insurance plan. I agree to be responsible for payment for services received and/or products purchased if these benefits are not covered by my insurance plan.

**SECTION 3:  
REGARDING REFERRAL AUTHORIZATIONS**

I understand that it is my responsibility to call my primary care provider to request a referral authorization, if the reason for my appointment requires one. I agree to call my doctor with this request prior to the visit or within 24 hours after the visit. I agree to be responsible for payment of services if a referral is not granted by my primary care provider.

Patient  
Signature \_\_\_\_\_

Date \_\_\_\_\_