



SKYVISION CENTERS

INSURANCE ADVANCED NOTICE

I have been notified by SKYVISION CENTERS that my procedure, _____, is an elective procedure and that I am fully responsible for the charges listed below. I understand that the charges listed below or a portion of the charges below may not be covered by my health insurance, despite the company's acknowledgement of the benefit, as I am choosing to undergo an elective procedure.

In the event that my claim, or a portion of my claim is not paid by my insurance, regardless of the denial reason or contractuals, I agree to pay the total balance due for the itemized charges listed below.

ITEMIZED CHARGES

PATIENT SIGNATURE

DATE