QUEENS EYE ASSOCIATES
29-03 Union Street
Flushing, NY 11354
718-463-3412

I understand that I am responsible for any co-payments that are linked to my examination and/or glasses/contact lens benefit through my vision insurance.

I also understand that medical testing may be necessary that will be billed to my medical insurance (e.g. diagnostic imaging and testing for ocular disease such as glaucoma, cataracts, etc.) I understand that I am responsible for any co-payments, co-insurances, and/or yearly deductibles that are linked to my medical insurance.

Name _____

Date _____

Signed _____