814 E. Jackson St. Ste A. Medford, OR 97504

(541)779-2525

OHP NOTIFICATION & WAIVER FORM

This form is to notify you that we are not contracted with the Oregon Health Plan, or Medicaid. This includes but is not limited to All Care, Jackson Care Connect and Open Card.

- I understand that InSight Vision Therapy cannot bill my insurance plan.
- I understand that there will not be a claim submitted to my insurance company for processing or payment.
- I understand that I am responsible for payment on this date of service.
- I agree not to submit a claim to OHP for services rendered at InSight Vision Therapy.
- I enter into this contract with the knowledge that I have the right to obtain Oregon Health Plan covered items and services from a physician and/or practitioner who is in network with OHP.

By signing this agreement, the patient, or the patient's parent or legal guardian, agrees to pay InSight Vision Therapy according to InSight Vision Therapy's fee schedule. Patient also agrees, understands, and expressly acknowledges the details of this contract.

_____ _____

Patient or Guardian's Name Patient or Guardian's Signature

_____ _____

Date Date of Service