**CASANOVA EYE CARE, APMC**

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NOTICE ABOUT YOUR HEALTHCARE PLAN

This notice is to inform you that some in-office procedures and testing done at the time of your visit may not be covered by your insurance copay; and may apply to your out of pocket expenses.

Upon signing this notice, you acknowledge that a payment above your copay may be required. These charges will be billed at a later date.

PRINTED NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_