



LASER VISION CORRECTION CLAIM FORM

Privacy Statement - The Spencer Health Network Inc is committed to protecting the privacy, confidentiality, accuracy and security of the personal information it collects, uses, retains and discloses in the course of conducting business.

PATIENT STATEMENT

Group Policy # _____ ID # _____

Mr. _____
 Mrs. _____
 Ms. Name (Print) _____

Relationship to Policyholder: Self Spouse Child Other _____

Date of Birth: (Mo,Day,Yr) ____/____/____

Address _____

City/Province _____ Postal Code _____

Telephone: Day () _____ Evening () _____

Telephone: Fax: () _____ E-Mail _____

I hereby consent to the release of any information or records concerning my refractive laser surgery, which is the subject matter of this claim, to The Spencer Health Network, Inc. (SHN). I also certify that the information I have given in this form is true, correct and complete to the best of my knowledge. Each of SHN and the centre performing the laser surgery that is the subject of this claim, (Centre), shall be solely and independently responsible for all claims, causes of action or other losses arising from any negligence or willful misconduct of its officers, directors, employees or representatives. Accordingly, each of SHN and the Centre hereby indemnifies the other of them and agrees to hold harmless the other of them and its directors, officers, employees and representatives from and against any and all claims, costs, expenses, damages and liabilities, including reasonable legal fees on a solicitor-client basis, incurred as a result of any claim, suit or proceeding made or brought against them resulting from or arising out of the alleged negligence or willful misconduct of the other of them and its directors, officers, employees or representatives, including, without limitation, any claims arising out of the refractive laser surgery. Patients are advised that SHN attempts to provide goods and services from qualified medical specialists and Centres, but that SHN makes no representations or warranties as to the quality of such goods and services, and in no event will SHN be liable to any patient or policyholder for any claims regarding the laser surgery that is the subject of this claim.

Patient _____
 Signature _____ Date _____

TO BE COMPLETED BY PRACTITIONER

Practitioner Name	City/Province	Telephone #	Date of Service
		Fax #	

	Laser Surgery	Total
Retail Price Paid		
SHN Use Only		

Complete this claim form and send or fax with receipts to:

**The Spencer Health Network, Inc.
 675 Cochrane Drive, East Tower – 6th Floor
 Markham, Ontario L3R 0B8
 Fax: 416-800-2708 (Claims Only)**

Patient Rx (Before Surgery)

	Sphere	Cylinder	Axis
R			
L			