SIGNATURE ON FILE

ACKNOWLEDGEMENT OF FINANCIAL POLICY

Our office is a vision provider for Vision Service Plan (VSP), Medical Eye Services (MES) and EyeMed, and a medical provider for Medicare, Cigna and Blue Cross PPO. If you have insurance benefits with any of these insurance plans, we will be happy to submit claims to them. Please provide your insurance information to the front office staff and we will verify your coverage as a courtesy. Accepting your insurance does not place financial responsibilities onto this practice. You will be responsible for any unpaid balances by your plan.

We do not accept insurance plans other than what is listed above. If you have an out-of-network insurance plan, services will be out of pocket. We require a copy of your current insurance card to properly submit claims to your plan. The patient will be responsible for payments if claims are rejected because improper information was given to our office.

By signing this statement, you agree to be financially responsible for all charges.

Payment or copayment is due, in cash or check, at the time services are rendered. Debit and credit payments may be accepted when a balance exceeds $20. Exceptions may apply. Any returned checks will be charged a $40 service fee and future services will require cash payment.

A minimum deposit of 50% is required to order glasses with the balance due upon delivery. Full payment is required to order contact lenses. **All sales are FINAL**. No refunds will be issued for services rendered or products purchased.

We do not double book appointments. The exam time is set aside for you. In exchange, we ask that you give us 24 hours' notice if you need to cancel or reschedule your appointment.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Your insurance company and its agents require us to release your medical information to them in order to determine benefits payable for services rendered in our office. **By signing this statement, you authorize the release of your medical information to your insurance company.** This assignment will remain in effect until revoked in writing. A photocopy of this assignment is as valid as the original. Review our Notice of Privacy Practices (NPP) form for complete terms.

Print name: _____

Signature: _____ Date: _____