Contact Lens Wearer Acknowledgment

Contact Lenses are considered medical devices and are regulated by the FDA. Since they fit directly on the surface of the eye extreme care and caution should be exercised in their use. Our office policy related to the purchases of contact lenses is as follows:

1. Contact Lens evaluations are separate from the comprehensive exam. This portion of the exam requires additional time from the doctor to ensure the health of the patient's cornea and eyelids, in addition to determining the size and type of contact required for the patient. This fee is nonrefundable. The first 30 days (after today) of contact lens related visits are free, after that time there is a $19.00 charge per visit.
2. When ordering contact lenses, payment is due in full or minimum of half at your time of service.
3. If you decide against contacts within 90 days of today (60 for RGP lenses), the amount paid on contacts will be refunded (less the $20 restocking fee for soft lenses, $50 for RGP's). Credit cannot be given for opened or damaged boxes of disposable contacts.

Patient or Parent Signature: _____ Date: _____

Acknowledgment of Notice of Privacy Policy

The notice of privacy policy is provided for you on the back of our clipboards. If you would like a copy of the notice for your records, please ask to have one provided. Please review the notice and complete the information below.

_____I have been presented with the notice of privacy policy for Precision Eye Care (the "provider") and have been offered a copy of such policy to keep for my records.

Do you give permission for a family member and/or friend to have access to your medical records, appointments, or billing at Precision Eye Care?

☐ Yes, please list names here: _____

☐ No, initial here: _____

Patient or Parent Signature: _____ Date: _____

Print Name: _____

Insurance Authorization Form

Please read the information below related to insurance coverage:

For routine vision coverage, verification and authorization of coverage is required. If your insurance company is closed or unable to be reached (evening or weekend hours), you will be required to pay in full today, but we will gladly file any paperwork needed for your reimbursement.

If you have Medicare and your supplement does not cross over, you will be responsible for paying the 20% not covered by Medicare and the $25 refraction fee, which is not covered. Medicare only pays for services related to MEDICAL EYE PROBLEMS, not routine vision.

Are you the primary policy holder? ☐ Yes ☐ No

If yes, please skip to the signature line at the bottom.

If no, please list:

Policy Holder: _____ SSN: _____ DOB: _____

I: Authorization to bill insurance on behalf of patient:

I authorize Precision Eye Care & Optical to bill my insurance and authorize the insurance company to pay any benefits due to them. From this day forward, I authorize the use of this signature on any and all my insurance submissions by this office and permit the release of any information necessary for the processing of any claims.

II: Patient Responsibility:

If you do not have insurance, payment is expected at the time of service unless prior arrangements have been made with this office. We will file your primary insurance as a courtesy to you. I understand that I am liable for payment of any portion of my claim not paid by my insurance, and further agree that the account balance is due in full, upon receipt of the statement. A $25.00 late charge will be added to overdue accounts. A $50.00 returned check fee will be added to all returned checks. You agree to reimburse us the collection fees of any collection agency, which shall be based on a percentage at the maximum rate of 33.5% of the amount due at the time your account is placed with a collection agency. You also agree to reimburse us all costs and expenses incurred for any collection efforts on your account, including reasonable attorney's fees incurred by the collection agency. This contract shall cover all medical treatment and services until revoked by either party in writing.

I understand and agree with the information listed above:

Patient or Parent Signature: _____ Date: _____

Print Name: _____