DRS. FACTOR & LANG
Optometry
4550 East Bell Road, #104
Phoenix, AZ 85032

I understand that insurance authorization/verification is NOT a guarantee of payment. Payment is determined by the insurance carrier after the claim is filed.

FINANCIAL AGREEMENT

I hereby authorize Drs. Factor & Lang Optometry to release information to any of my insurance companies when necessary to complete my claim. I understand that I am financially responsible for items not covered by my insurance such as co-payments, deductibles, denied items, and non-covered services. Except for items filed to insurance, payment is required at the time services are provided unless other arrangements have been made in advance. Drs. Factor & Lang Optometry accepts cash, personal checks, Care Credit, Visa, MasterCard, Discover, and American Express credit cards.

Patient Signature: _____ Date: _____

CONSENT TO TREAT

I consent to the administration and performance of such medical treatments and diagnostic procedures as may be deemed necessary during my appointment by my optometrist or his/her assistants.

Patient Name Printed: _____ Date Signed: _____

Patient Signature: _____ Preferred Name: _____

If Patient is a minor

Parent/Legal Guardian Signature: _____ Relationship: _____

MAIL, TELEPHONE CALLS, AND EMAIL CONSENT

If at any time I provide a telephone number at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing and payment for items and services, unless I notify the office of the contrary in writing. In this section, calls and text messages include but are not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging, or by any other form of electronic communication from Drs. Factor & Lang Optometry, its affiliates, contractors, services, clinical providers, attorneys, or its agents including collection agencies.

If at any time I provide an email address at which I may be contacted, unless I notify the office of the contrary in writing, I consent to receiving communications regarding billing and payment for items and services at the email address from Drs. Factor & Lang Optometry, its affiliates, contractors, services, clinical providers, attorneys, or its agents including collection agencies. The undersigned acknowledges they will receive mail from the office at the address provided, including but not restricted to communications regarding billing, payment, and eye care related matters.

Patient Signature: _____ Date: _____