STATEMENT OF FINANCIAL RESPONSIBILTY:

If the doctor finds a medical problem, your MAJOR medical insurance company and/or you may be liable for additional charges, which may be over and above the vision benefits you are eligible for through your VISION plan.

For reimbursement, I authorize my insurance policy to pay the provider directly. I understand that should my insurance company

- Fail to remit a payment, or
- Remits an insufficient payment, or
- Fails to remit a payment within 60 days from date of service,

I will be responsible for all charges incurred.

Patient signature_____ Date _____

RETURN POLICY:

Please understand due to the nature of customizing ophthalmic lenses, we have a 30 day return policy should there be any concerns or complications. After this 30 day period, we cannot be responsible for any adjustments or changes that need to be made.

Custom contact lenses (non disposable) will be returnable within 30 days from the initial date of order with a restocking fee of 50% of the lenses. Contact lens exam and all professional fees are non refundable.

Patient signature_____ Date_____

NOTICE OF PRIVACY PRACTICES:

Our notice of Privacy Practices provides information about how we may use and release protected health information about you. You have the right to review our notice before signing this form. By signing this form, you consent to our use and release of protected health information as described in our notice. You have the right to revoke this consent in writing, except where we have already made releases in reliance on your prior consent.

Patient Name (Print)_____

Signature_____ Date_____