STATEMENTS OF FINANCIAL RESPONSIBILITY:

Vision plans **do not cover** the treatment and management of medical eye conditions (for example: dryness, red eye, etc.). If you present with a medical problem or the doctor finds a medical problem that requires immediate attention, **your major medical insurance and/or you will be liable for the fees for your visit**. 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 90 day return policy should there be any concerns or complications. After this 90 day period, we cannot be responsible for any adjustments or changes that need to be made.

Custom contact lenses are returnable within 90 days from the initial date of order with a restocking fee of 20% 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_____