

The Following Policies Will Apply

- I. Any patient not having insurance is responsible for the full balance of the eye exam or office visit. This must be paid in full on the service date. Materials must have a deposit made before the order can be placed, and the balance due is paid on the day of dispensing. If necessary, payments can be made and glasses dispensed when final payment is received.
- II. All eye exams, office visits, and materials will be billed directly to **ACCEPTED** insurance providers; in some cases insurance can be submitted by patients. All patients with accepted insurance are responsible for paying their balances (including co-pays) that are not covered by their insurance plans on exam/visit dates. Patients are responsible for paying the full balance of their eye exam/office visits if their insurance providers are not accepted by this office; materials can carry a balance until the dispensing date.
- III. All eyeglass prescriptions will be held until payments are made in full. All frames have a 1-year warranty against breakage. All lenses, with either scratch guard or anti-reflective coating, have a 1-year warranty against scratches. No-line bifocal/progressive lenses have a 60-day non-adapt manufacturer's warranty. If you cannot adapt to these lenses, they will be remade into traditional trifocal, bifocal or single vision lenses at no additional cost BUT you will not receive a refund.
- IV. All contact lens records (including prescriptions) are part of the medical record. All contact lenses and replacement lenses must have a deposit made and balance paid in full on the dispensing date. Patients must return for a contact lens follow-up before this office will order their prescription lenses or release any prescriptions. Should someone want his/her contact lens prescription, it will be provided upon request **IF** the individual's exam and evaluation for contact lens fees have been paid.
- V. This office accepts cash, check, Visa, MasterCard, American Express, and Discover.

HIPAA Acknowledgment and Consent

I acknowledge that I have been given an opportunity to review Family Vision Clinic's Notice of Privacy Practices. This acknowledgment is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

I have read and thoroughly understand the above policies.

Patient or Guardian Signature

Date

For those with approved insurance, please read and sign the statement below.

Assignment of Benefits

I authorize Dr. Martin B. Gresak and staff to release any medical and/or other information necessary to process my insurance claim. I also request assignment of benefits be made to Dr. Martin B. Gresak or Family Vision Clinic on my behalf. I understand that I am responsible for any amount not covered by my insurance. This order shall remain in effect until revoked by me.

Patient or Guardian Signature

Date

Thank you for allowing Family Vision Clinic to provide your vision care.