



Patient Acknowledgment of Fees

There is a \$25.00 returned check fee that will be charged to the responsible party if a check has insufficient funds.

Signature of Patient/Responsible Party

Date

Patients with Medical Coverage Only!!

Due to change of reimbursement policies with local carriers, we have been instructed to charge for refractions. A refraction is the lens prescription that Eye Care One creates for your glasses to ensure the best possible vision. Currently, Medicare does not reimburse for refractions. The charge will be \$40.00. This will only be charged, at the most, twice a year, depending on your medical condition. This only applies to those that do not have routine vision coverage.

Signature of Patient/Responsible Party

Date

AUTHORIZATION TO RELEASE INFORMATION/PAYMENT AGREEMENT

I authorize the release of medical information necessary to process insurance claims. A copy of this authorization may be used in place of the original. This authorization may be revoked upon my request in writing. I understand that I am responsible for all professional services and or supplies rendered to either myself or my dependent. I understand that this office will submit my insurance claim for me, as a courtesy, but that it be my responsibility to pay for services rendered. I further understand that if my insurance does not pay for services in full, it is my responsibility to pay for the non-covered, allowable charges within thirty days.

Signature of Patient/Responsible Party

Date