Payment: Payment is due at the time of service. This includes co-pays and anything not covered by insurance. We accept checks, cash, Visa, MasterCard, Discover and American Express.
Initial:_____

Unpaid balances, collections and insufficient funds: We will notify you by mail or phone regarding any unpaid balance. You have the right to ask at the time of service, prior to the test being performed, if any additional charges will be incurred. If you fail to do so you waive the right and will adhere to the customary billing and collection policies. Collection agencies are used only when necessary.
Initial:_____

Insurance: Your bill is your responsibility. We will do our best to help you understand your coverage, and we will file insurance as a courtesy to you whenever possible. Any existing balances after your claim is filed are due immediately. We will call you or send a statement to explain any of the charges, payments and amounts owed. **Verification of insurance benefits does not guarantee payment for services rendered.**
Initial:_____

Medical insurance vs. Vision insurance: Medical insurance can be filed for some diagnoses, such as conjunctivitis (pink eye), foreign bodies in the eye, glaucoma or suspicion of glaucoma, diabetes in the eye, cataracts, floaters, etc. Vision insurance, if you have separate coverage, usually pays toward an annual routine eye exam and contributes toward glasses or contact lenses. We will obtain insurance authorization on your vision insurance (VSP, Eyemed), and require copies of your all insurance cards.
Initial:_____

Vision Insurance: Please let us know which Vision Rider, if any, you have **Circle (any that apply)** Vision Service Plan, Eyemed, Cigna Vision, Blue View Vision, MetLife Vision, Humana Vision, Uniview Vision, Davis, Optum Health Vision

Refunds: Any refunds on your account will be processed as promptly as possible. They will be provided after all insurance on the account has been paid. Refund checks are processed monthly.
Initial:_____

Appointment times: Appointments can be made by phone. Please let us know as soon as possible if you cannot make a scheduled appointment so we might use that time for other patients. You understand that we may remind you of appointments by phone.
Initial:_____

Dilation: Side effects can include light sensitivity, difficulty focusing, glare disability, problems reading or with near tasks, and driving difficulties. You can request post-dilation sunglasses.
Initial:_____

Refraction: We determine the prescription required for your eyeglasses or contact lenses. For patients with medical and eye health diagnoses, this is often a necessary special test. Insurance companies require us to bill this separately. Medicare does not cover refractions. The charge is $49.
Initial:_____

Coordinated care: Our doctor can treat an array of eye problems and diseases. Should the need arise for a surgical or other consultant on your case, your signature at the conclusion of these forms is your authorization for our doctor to discuss, share and transfer any and all clinical information and data pursuant to your care.
Initial:_____

Glasses: **All prescription glasses are considered custom eyewear and cannot be returned**. However, there is a 1 year breakage warranty on frames and one year warranty on scratched lenses. Lenses will be replaced at 50% usual and customary cost. Restrictions may apply. Glasses not purchased through our optical department are adjusted at your own risk.
Initial:_____

Contact lenses: Contact lens wear requires additional testing, evaluation and follow-up to ensure proper eye health and performance. There are additional fees associated with a contact lens evaluation beyond a normal eye exam. **These fees are annual and are determined by the complexity of the case and time required**. Contact lenses may be returned if **box is unopened and not damaged.**
Initial:_____

HIPAA Privacy Practices: You understand that under the "Health Insurance Portability & Accountability Act of 1996" you have certain rights to privacy regarding your protected health information. You acknowledge that you have been informed and had access to Notice of Privacy Practices containing a more complete description of the uses and disclosures of your health information. You understand that Seymour Optometric Center has the right to change their Notices of Privacy Practices from time to time and that you may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.
Initial:_____

Authorization, assignment and release: Your signature below authorizes Seymour Optometric Center and its agents to release any and all information related to you or your dependent's care for the purpose of obtaining insurance compensation, pre-certification or medical records**. By signing, you also acknowledge that you understand that Medicare or your insurance carrier may not cover all services. You will be fully responsible for any and all charges not covered by your insurance.** Furthermore, you request that all payments on your behalf be paid directly to Seymour Optometric Center. These assignments will remain in effect until revoked by you in writing.

_____
Patient Signature (or Responsible Party if patient is a minor)
Date_____

_____
Please print name of patient
Date_____