Financial Responsibility: I agree to be responsible for payment of all The Eye Sites' charges. I also agree to be responsible for all professional fees covered by insurance or not. I understand the Eye Site is an independent practice and will bill me, my family, and /or other responsible parties for services provided. I understand for any balances unpaid over 30 days will be subject to a **$10.00 per month late charge.** The Eye Site uses an outside collections agency for any balance unpaid after 90 days.

Insurance Coverage: There are two types of health insurance that will help pay for your eye health services and products. The Eye Site accepts most plans in each category: **(1) vision plans** and **(2) major medical insurance**. Vision plans cover ONLY routine vision exams which may include eyeglasses and contact lens materials. Vision plans DO NOT provide for MEDICAL eye health needs. Medical insurance MUST be submitted for any medical eye diagnosis and treatment. If you have both plans it may be necessary for us to bill different plans for different services to maximize your benefits and provide the most cost effective treatment. Fees, services, and products not paid by either plan will be the patient's responsibility, including deductibles, co-payments, and non-provider services specified by the insurance plan.

Cancellation/No Show Policy: Your scheduled appointment time has been reserved for you. Please notify us 24 hours prior to your appointment if you need to cancel or reschedule your appointment. We are aware that unforeseen events can happen and you may need to cancel your appointment. Please let us know so we can arrange for other patients to come in. If you do not show up for your appointment or cancel with the appropriate advanced notice, there will be a **no-show fee of $25 applied to your account.**

Notice of Privacy Practices HIPAA

I have been provided an opportunity to review the Notice of Privacy Practices, (available upon request) and agree to the terms and conditions above:

Patient Name (print): _____ **DOB:**_____

Signature:_____**Date:**_____

(If patient is under 18 *parent or guardian* **must sign**)

Please List Person(s) who may access your records: (Additional family members)

_____, _____,

Email Address

If you would like the option of having your prescriptions, receipts, and/or other information emailed to you please provide a current email address below

Email Address: _____