



Service Fees All professional services (exam, contact lens fitting, and/or follow-up fees) are non-refundable. _____

Cancellation An optical order can be cancelled for a full refund only if the job has not been processed. Once processed, there will be a **50%** cancellation fee for the cost of the lens. A restocking fee of **\$30** will apply for the frames. _____

Outside RX A valid prescription from another office may be filled at our establishment. If a doctor's change in prescription is needed, one lens remake can be processed within 60 days of the original order at no additional cost. The prescribing doctor must provide a new prescription in writing before the remake. For any additional changes, a fee will be applied. _____

Non-Adaptation Due to the complex nature of glasses, patients are encouraged to give their eyes time to adapt to a new prescription. Patients are entitled to **one** remake if adaptation does not occur; order must be processed within 60 days of the original purchase date. There is no refund for the difference in cost if the new lenses are of lesser value. _____

Contacts Contacts may not be returned if the boxes have been opened or if the packaging has damage of any kind. A refund may be given if the boxes are unopened. A 10% restocking fee will be deducted from the refund. _____

Patient Signature Date

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our offices.

We have a comprehensive Notice of Privacy Practices that describes these uses and disclosures in detail. You are free to refer to this Notice at any time before you sign this consent document. As described in our Notice of Privacy Practices, the use and disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes our submission of your health information to a billing agent or vendor for processing claims or benefits and payment our submission of your health information to auditors hired by third-party payers and insurers, among other aspects of payment described in our Notice of Privacy Practices. Our Notice of Privacy Practices will be updated whenever our privacy practices change. You can get an updated copy here at the office or from our website.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services, and perform health care operations. By signing, you signify that you have no other health or vision insurance (or that you have provided us all insurance information) and agree that, since there is no guarantee of payment by an insurance company, you will be responsible for payment for services, or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent. We can decline to serve you if you elect not to sign this consent form.

We have the right to ask us to restrict the use or disclosures made for purposes of treatment, payment of health care operations, but as described in our Notice of Privacy Practices, we are not obligated to agree to these suggested restrictions. If we do agree, however, these restrictions are binding on us. Our Notice of Privacy Practices describes how to ask for a restriction.

I HAVE READ THIS CONSENT AND UNDERSTAND IT. I CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

Date Signature of Patient

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form.

Relationship to Patient Print Name

Source of Authority