Please read and acknowledge our OFFICE POLICY

1. All professional fees and hardware fees are due and payable at the time of service and are non-refundable.
2. If needed, a courtesy spectacle recheck must be done within 60 days from your initial exam or there will be a $25 office visit. After 6 months from your initial exam, a new exam will be required.
3. One courtesy lens power change will be granted if needed within 60 days. If there is a non adaptation to 1st time progressive lens wearer, there is a courtesy refit to a different lens. Additional charges may apply.
4. Contact lens evaluations include 3 follow ups visits within 60 days. There will be a $25.00 charge per office visit after 60 days or more than 3 visits. After 6 months from your initial exam another complete eye exam will be required
5. Contact Lens refits to a different lens will incur another evaluation fee.
6. Spectacles sales are final.
7. Unopened, unmarked, unexpired contact lens boxes may be exchangeable.

I acknowledge that I have received, read, and agreed to the Office Policy

Parent/Patient's Signature____ Date______________

Acknowledgement of Review of Notice of Privacy Practices, Frisco Eye Clinic

I have been offered and/or reviewed the Notice of Privacy Practices which explains how my medical information will be used or disclosed. I understand I am entitled to receive a copy of the Privacy Practices. The Notice of Privacy Practices may also be found at www.friscoeyeclinic.com.

Initial Here ____________

General Consent to Treat

I, knowing that I have a condition requiring diagnostic or medical treatment do hereby voluntarily consent to such procedures and care by Dr. Pearson, Dr. Buthod, or designee as necessary in his/her judgment.

Initial Here ____________

Third Party Reimbursement Policy and Refraction Policy

Refraction is the process of determining the eyes refractive error or need of corrective spectacles and/or contact lenses. This is NOT covered by Medicare/Medicaid and may or may not be paid by other medical insurances. All vision insurance must be pre-approved prior to your examination. If we are unable to verify coverage, all charges must be paid in full when services are rendered. If you are not eligible for insurance benefits, or are eligible for less than full coverage, your initial and signature below indicates that you agree to be financially responsible for any unpaid balances. Professional service fees are non-refundable.

Initial Here ____________

Authorization Release of Medical Information

I certify that the above information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to Frisco Eye Clinic on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Centers for Medicare Services and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the CMS-1500 claim form or electrically submitted claim), my signature authorizes release of medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

Initial Here ____________

______________________________ ______________________________
Patient (Guardian) Signature Date

______________________________ ______________________________
Doctor Signature Date