FINANCIAL & PRIVACY AUTHORIZATION

We request your signature on file, in the event the office files insurance on your behalf for any office procedure. Your signature authorizes the use of this form on all of your insurance submissions, and it permits a copy of this authorization to be used in place of the original. A copy of this authorization will remain on file for a period of ONE YEAR.

_____ (initial here) I hereby authorize treatment by Yadkin Vision Center O.D., PLLC, and I understand that I am financially responsible for all charges for services rendered, including the balance remaining after **possible** insurance benefits. I authorize the release of any medical information necessary to process my insurance claim(s) and the sending of any necessary information to another physician. I assign and request insurance payments be made directly to Yadkin Vision Center O.D., PLLC.

_____ (initial here) It is the policy of Yadkin Vision Center O.D., PLLC that all fees, both for professional services and optical goods, be paid in full at the time services are rendered. Payment may be made with cash, Visa, MasterCard, Discover or an appropriate check. Any returned checks will be subject to a **$35.00 processing fee**.

_____ (initial here) Some medical insurances do not cover the charge for a **refraction**, because it is considered routine vision testing. In the event that your insurance does not cover the refraction and one is performed, you understand that you will be responsible for the cost of the refraction (the charge is currently $39.00).

_____ (initial here) Eyeglass Policy: All eyeglasses must be paid for in full at the time of dispensing. In the unlikely event you encounter problems with your glasses, it is imperative that we be notified within 30 days of the original dispensing date of the eyewear. Our office will work with you to correct problems you may have. Prescription eyewear is custom made for each individual. Therefore, glasses cannot be returned for a refund. Frames have a manufacturer's warranty for one year from the date of purchase that covers breakage due to manufacturer's defects, NOT from damage due to accidents, improper handling, abuse, or normal wear and tear. This warranty does not apply to frames that have been discontinued or purchased on clearance.

_____ (initial here) Contact Lens Policy: All contact lenses must be paid for in full at the time of dispensing. Non-disposable contact lenses may not be returned unless the lens material is defective or the lens is under the manufacturer's warranty. Any unopened, unexpired boxes of disposable contact lenses may be returned within **6 months** of purchase for credit towards other contact lenses. The boxes must be in their original condition.

_____ (initial here) NOTICE OF PRIVACY PRACTICES: A copy of our privacy policies is available on our website and at the front desk upon request. I acknowledge that I have been offered a copy of the Privacy Practices of Yadkin Vision Center O.D., PLLC.

**** <u>Please list below the name of anyone with whom we may discuss your health/account information</u>:**

Patient/Responsible Party Signature_____

Patient/Responsible Party Name (Please Print)_____

Today's Date_____