

PATIENT CONSENT AND WAIVER FORM

I, _____, understand that I am or will be responsible for all charges associated with today's visit and any subsequent visits relating to the diagnosis, testing, and treatment of any and all eye conditions, including but not limited to the following items:

- **REFRACTION**: An eye refraction is the test used to determine your prescription for glasses. This service is not covered by Medical Insurance. The fee for this service is \$30.00 and is due at the time of service. This may be covered by your Routine Vision Benefit, if you have it.
- **NO REFERRAL AT TIME OF VISIT**: If you did not bring or have a valid referral at the time of your visit and still wish to be seen, you will be responsible for all charges.
- **NO INSURANCE**: You will be responsible for all charges associated with all visits.
- **WORKMEN'S COMPENSATION CLAIMS**: If provided with the proper billing information for your Workmen's Compensation claim, we will bill your employer and /or the insurance carrier for your visit(s). We will do this only **ONCE**. If payment is not received in a timely manner or the claim is denied, you will be responsible for all charges.
- **MISSED APPOINTMENTS**: Appointments are confirmed prior to your appointment date. If an appointment is cancelled up to 24 hours prior to your appointment, you will not be charged. If you fail to show for your confirmed appointment, you will be charged \$25.00. If multiple family members have appointments on the same day, each person who fails to show is charged \$25.00.
- **CHANGES IN INSURANCE**: All co-pays and fees are due in full at time of service.
- **DELINQUENT ACCOUNTS**: In the event that your account becomes delinquent, you will be liable for all reasonable collection/attorney fees plus filing cost and processing fees.

Patient's signature or responsible party

Date