Drs. Boeck & Schisler, Optometrists

PATIENT NAME (GUARDIAN IF UNDER 18):_____

PRIVACY POLICY

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 services, and to conduct healthcare operations involving our office. The Privacy Policy describes these uses and disclosed in detail. I acknowledge that I have been offered and /or received a copy of the Privacy Policy from Drs. Boeck & Schisler Optometry.

Date Signature

FINANCIAL DISCLAIMERS

Returns and Refunds

Because eyeglasses are custom made for each individual we are unable to offer refunds for eyeglasses. In the event of a problem, every effort will be made to exchange or redo the glasses to make any necessary changes. We are also unable to return opened boxes of contact lenses. In the event of a prescription change we may offer to exchange unopened boxes for the appropriate replacements with in a 6 month period._____ INITIALS

Eligibility for medical insurance and/or routine vision benefits

We will attempt to verify your plan eligibility for services and/or materials before your appointment. ***Verification of eligibility is done as a courtesy only and is not a guarantee of payment.*** Please check with your plan administrator if you have any questions regarding your eligibility. Drs. Boeck & Schisler Optometry does not participate in any HMO plans._____INITIALS

Liability

If I have medical insurance or routine vision benefits, I authorize my plan carrier to directly pay Drs. Boeck & Schisler Optometry. I also authorize Drs. Boeck & Schisler to release any information required for payment to be made. ***If my plan carrier does not pay or partially pays, I understand I am responsible for payment in full or the remaining balance.*** My signature below verifies that I understand this agreement and the above financial disclaimers.

Date Signature

CONTACT LENS FEES

Contact lens evaluation and fitting services are not an included part of an eye health evaluation and vision assessment, and additional fees apply. Fees are customized according to the complexity of the case and the predicted times necessary to care for the individual patient.

Fees for contact lens fitting services (includes trial pair of contact lenses, follow up appointment, and upon completion of trial period one written copy of your contact lens prescription) range between $90.00 and $360.00. As with glasses, contact lens materials are an additional fee. There is a $5.00 fee for each additional copy of your prescription. My signature below verifies I understand the contact lens fees.

Date Signature

REFRACTION FEE

The part of your evaluation that determines your prescription is called refraction. A refraction is also done under certain circumstances for diagnostic purposes. ***If you have routine vision benefits such as VSP, MES, TriCare, your refraction is typically includes with your exam benefits. Medical insurances that do not include routine vision benefits, such as Medicare, do not cover a refraction. The fee for a refraction is $55.00 and includes one written copy of your glasses prescription There is a $5.00 fee for each additional copy of your glasses prescription.*** My signature below verifies I understand the refraction fee.

Date Signature