EMINENCE
FAMILY EYECARE

Office Policy /Financial Information/privacy practices

1. **Prescription Re-check:** Glasses re-checks will be performed and are subject to no charge within 30 days of original date of eye exam. All glasses re-checks after 30 days are subject to an Office visit charge.

2. **Contact Lens Patients:** Please be aware that certain lens fitting types (Sclerals, RGP, Soft Toric, Multifocal, Monovision etc.) require more time and measurement on the part of the doctor and extra fitting fees apply. Contact lens follow-ups are often indicated and will be provided to address contact lens fitting issues at no additional charge for 60 days from the initial fitting date. This includes 3 follow-ups. After 60 days or after 3 follow-ups an office visit fee will be charged.
   By Georgia Law, a contact lens prescription is valid for one year. No contact lens can be given by the doctor or sold by the optical after the one-year expiration date. New contact lens wearers will need to demonstrate the technique of proper insertion and removal of contact lenses before the lenses can be released by the office. If further time or instruction for insertion and removal is needed, the patient may return at NO additional charge for up to 30 days

3. **Refunds:** All eyewear purchases are final sale but patients seeking refunds can receive store credit which can be used for future eyewear purchase. All fees for professional services rendered by the doctor are **non-refundable**. Patients can request re-checks at no additional cost.

4. **Insurance Patients:** While we make every effort to verify and confirm your insurance benefits, it your responsibility to understand the terms and conditions of your insurance plan. Please be aware that some services provided may not be covered by your insurance. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old will be subject to collection fees. There will be a service charge of $25 on all returned checks.

Payment from my insurance is to be paid directly to Eminence Family Eyecare and I understand that (name of vision or medical insurance) _____will be billed as my primary insurance. I understand that billing any secondary insurance is my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made once the claim is processed. Patients are responsible for all charges their insurance carrier does not cover with applicable co-pays due at the time of service. I understand that any cost (such as collection fees, mailing cost, court and legal fees) will be added to my bill if these procedures are required to secure payments.

HIPAA / PRIVACY PRATICES: All doctor's offices must keep your personal information confidential due to a law known as **HIPAA**. I understand that the privacy rights are posted and a copy is available to read at any time. I also understand that I may request a copy for my personal records. I consent to the release of my health information for treatment, Insurance payments and health care operations and as authorized or required by law under the circumstances described in the Notice of Privacy Practices. Furthermore, I **DO** authorize Eminence Family Eyecare to release my records to any other physician or third party participating in my care. I have received, read, and understand your Notice of Privacy Practices. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization any time to obtain a current copy. I understand that I may request in writing that the office restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that the office is not required to agree to my requested restrictions, but if they do agree, they are bound to abide by such restrictions.

By signing below, you understand and agree with the above statements:

Printed Patient Name:_____

Patient/Guardian Signature: _____ Date: _____/_____/_____