LA PAZ OPTOMETRIC CENTER

Patient's Name: _____

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 health care operations involving our office. The Privacy Policy describes these uses and disclosures in detail.

I acknowledge that I have been offered and/or received a copy of the Privacy Policy from La Paz Optometric Center.

_____ _____

Signature Date

FINANCIAL DISCLAIMERS

_____
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. La Paz Optometric Center only participates in select HMO plans.

Liability

I understand that account balances and co-payments are due at time of service. If I have medical insurance or routine vision benefits, I authorize my plan carrier to directly pay La Paz Optometric Center. I also authorize La Paz Optometric Center 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 for the remaining balance.*** My signature below verifies that I understand this agreement and the above financial disclaimers.

_____ _____

Signature Date

CONTACT LENS FEES

Contact lens evaluation 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 time necessary to care for the individual patient. ***Fees for contact lens evaluation services range between $60 and $350. As with glasses, contact lens materials are an additional fee.*** My signature below verifies I understand the contact lens fees.

_____ _____

Signature Date

CANCELLATION POLICY

Our office policy requires a twenty-four (24) hour cancellation notice. There will be a $25.00 charge to your account for each uncommunicated cancellation.

_____ _____

Signature Date

REFRACTION FEE (MEDICARE)

The part of your evaluation that determines your prescription is called a refraction. A refraction is also done under certain circumstances for diagnostic purposes. ***If you have routine vision benefits, your refraction is typically included 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 $50.*** My signature below verifies I understand the refraction fee.

_____ _____

Signature Date

25260 La Paz Road, Suite G, Laguna Hills, CA 92653
(949) 586-8200 • Fax (949) 586-1538 • www.lapazoptometric.com