

NAME: \_\_\_\_\_  
THIS NOTICE APPLIES TO THE FOLLOWING FAMILY MEMBERS:

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**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 insurance 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 disclosures in detail.

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

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DATE

SIGNATURE

**FINANCIAL DISCLAIMERS**

**Eligibility for medical insurance and/or routine vision benefits**

**LIABILITY**

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.

I understand that account balances and co-payment are due at time of service. If I have medical insurance or routine vision benefits, I authorize my plan carrier to directly pay Dr. Hyman. I also authorize Dr. Hyman to release any information required for payment of 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. **Professional fees are non refundable. There is a 25% restocking fee for cancellation of any order once placed.** My initials below verify that I understand this agreement and the above financial disclaimers.

\_\_\_\_\_ INITIALS

**CONTACT LENS FEES**

Contact lens evaluation services are not an included part 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 \$50 and \$200. As with glasses, contact lens materials are an additional fee.**

\_\_\_\_\_ INITIALS

**REFRACTION FEE**

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 such as VSP, EyeMed or Medical Eye Services, your refraction is typically included with your exam benefits.** Medical insurances that do not include routine vision benefits, such as Medicare, do not cover refraction. **The fee for a refraction is \$25.**

\_\_\_\_\_ INITIALS