# Complete Eye Care, PC

**PLEASE FILL OUT COMPLETELY**

## Acknowledgement of Receipt of Notice of Privacy Practices

*Complete Eye Care, PC reserves the right to modify the privacy practices outlined in the notice.*
*I have received a copy of the Notice of Privacy Practices for Complete Eye Care, PC.*

*Complete Eye Care, PC has my permission to call my home, leave a message with persons other than myself or on an answering machine that I need to call the office.*

*Complete Eye Care, PC has my permission to call my home to discuss appointments, scheduling of tests and/or surgeries and subsequent results.*

In addition to myself I authorize my medical information be released to:
Name: _____ Relationship: _____
Name: _____ Relationship: _____

## Refraction Policy, Missed Appointment & Insurance Assignment/Financial Agreement

**Missed Appointment Policy**
I understand that failure to show up for a scheduled appointment inhibits other patients from being seen. I also understand that Complete Eye Care, P.C. will assess a $50.00 charge to my account the **second** time I fail to show up for an appointment without giving 24 hour prior notice. I understand that my insurance will not pay this fee and I agree to personally pay the $50.00 fee per the terms of the above Financial Assignment/Agreement.

**Insurance Assignment/Financial Agreement**
1. I/we authorize Complete Eye Care, PC to convey to the insurance company, employer or attorney listed above or their representative or group or association any and all information it possesses relative to the services provided.
2. I/we understand that any and all co-pays, deductibles, etc that are not paid by the insurance company is the responsibility of the patient/responsible party. The contract for health insurance is between the patient/responsible party and the insurance company, **not** between Complete Eye Care, PC and the insurance company. Claims for services will be filed with the insurance company but all balances left unpaid by the insurance company is the responsibility of the patient/responsible party.
3. I/we hereby authorize and direct any insurance company or carrier or any attorney representing the insurance or the patient seeking to collect insurance, Workman's Compensation benefits or damages for personal injuries to deduct and pay direct to Complete Eye Care, PC from the proceeds of any insurance compensation benefits or damages due to be paid or paid any and all sums certified by Complete Eye Care, PC to be due by reason of services rendered to said patient.

4. I/we hereby guarantee payment of all charges incurred for the account of the above named patient. In the event of default, I will be responsible for all costs of collection including reasonable attorney fees and court costs. I understand that a finance charge of up to 18% annually may be charged to my account. I/we authorize Complete Eye Care, PC to convey to the insurance company, employer or attorney listed above or their representative or group or association any and all information it possesses relative to the services provided. I/we hereby authorize and direct any insurance company or carrier or any attorney representing the insurance or the patient seeking to collect insurance, Workman's Compensation benefits or damages for personal injuries to deduct and pay direct to Complete Eye Care, PC from the proceeds of any insurance compensation benefits or damages due to be paid or paid any and all sums certified by Complete Eye Care, PC to be due by reason of services rendered to said patient.

**Refraction Policy**
**Medicare** and most commercial insurances do not pay for what they consider routine eye care. A refraction is considered routine care that is not paid by Medicare or most commercial carriers. A refraction may be necessary even if you don't want glasses or contact lenses for the doctor to determine how well you can potentially see. Therefore, **the fee is $50; however, if you pay at the time of service, you will receive a $20 discount making the fee $30.** This is in addition to the fee for your medical evaluation.

**Patient/Responsible Party Signature:**_____
**Patient Printed Name:** _____