HIPAA

Patient Name (Printed):_____

Please sign below

If your exam is classified as MEDICAL, we will bill your medical insurance as primary, as your vision insurance does not cover medical exams. You could be responsible for any co-pays or deductibles that may come to you from your insurance. Medical exams include, but are not limited to Diabetic exams, dry eye, allergies, eye emergencies, eye infections, cataracts, glaucoma and macular degeneration.

We are happy to process any insurance forms for optical or medical benefits you may have as a courtesy to you. However, since we may be in network with your insurance carrier, it is not our policy to contact carriers to establish why they have not paid or why they paid less than anticipated. Please understand that lenses and eye care costs may exceed the insurance payment, and that you will be financially responsible for all charges, whether or not paid by insurance. We do require that your portion of the total cost for professional services be paid in full at the time of your visit. A 50% payment on eyeglass or contact lens orders is required at the time they are ordered.

Your optical purchase is a custom order that cannot be resold and therefore it is non-refundable. The order cannot be canceled after it has begun. We will, however, work with you to assure your satisfaction with the products your have selected.

I have read and understand the above information regarding payment policies, OPTICAL/MEDICAL insurance and optical purchases.

By signing this, I acknowledge and understand the Notice of Privacy Practices (a standard HIPAA compliant document), which is available upon request. I also acknowledge I have a legal right to my finalized prescription per the eyeglass and contact lens rule.

X_____ _____

Signature of Patient or Guardian **Date**

Additional person(s) who have my permission to view my records, disclose any information, or pick up my orders:

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ALPINE FAMILY EYECARE