

C&R Vision Center

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Please Initial:

_____ Routine Appointments with Medical Findings: You are responsible for the MEDICAL copay, in addition to the Routine copay which may be different.

_____ Contact Lens Wearer: A Contact Lens Evaluation Fee is due yearly at your routine appointment. Charges may vary depending on lens type.

_____ Deductible Insurance Plans: Charges are due the day of the appointment for all Routine exams. A billing charge may apply if not collected on the date of service.

Notice of Privacy Practices

Please Initial:

_____ I authorize the release of any Protected Health information (PHI) necessary to process the claim. I also authorize direct payment of medical benefits to my doctor.

_____ I understand that verification of coverage is not a guarantee of payment. Actual payment will be made when a claim is received, and I will be responsible for any balance my insurance company does not cover.

_____ I have been given the opportunity to read/or receive a copy of this office Notice Of Privacy Practices.

_____ I authorize to release my records/information to the following people:

Patient Name(print): _____ Date of Birth: _____

Signature/Guardian: _____ Date: _____

Relationship to Patient: _____